CHARACTERISTICS OF WOMEN HAVING REPEAT ABORTIONS

A DISSERTATION

SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS OF

THE DEGREE OF DOCTOR OF PHILOSOPHY

BY

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ATLANTA, GEORGIA

JULY 1990

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ABSTRACT

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Dissertation dated July, 1990

The primary purpose of this research study was to examine a profile of characteristics of women who have had repeat abortions. A secondary purpose was to describe the risk-taking behavior, sexuality, quality of sexual relationships, and attitudes toward children of a selected group of women who had repeat abortions. Of the four hypotheses posed which were related to these four factors, all were rejected.

The sample consisted of 57 women who were patients in a private clinic. These women were in their first trimester (seven to twelve weeks) of pregnancy and were seeking an abortion. The subjects completed the Pre-Abortion Counseling Survey. Frequency Analysis in numbers and percentages were employed to analyze the data.

ACKNOWLEDGEMENTS

My sincere thanks go to Dr. Gaylene Perrault, my dissertation advisor, who gave me her valuable time, constructive criticism, encouragement, and advice. My deep gratitude goes to Dr. Rudolph V. Green for always being supportive and encouraging in all aspects of my doctoral program. I would also like to thank my professors at Clark Atlanta University from whom I have learned so much about Counseling and Human Development. My special thanks go to Dr. W. Clinton Pettus at Virginia State University for being my "mentor" throughout my undergraduate and graduate years of school. Finally, I would like to extend my deepest heartfelt thanks to my grandparents, parents, and my twin brother for being a wonderful family with constant love and support during my academic and professional development.

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CHAPTER I

Introduction

The contemporary world is marked by moral conflict. This conflict has deep historical roots and is reflected in social institutions, practices, laws, norms, and values. The abortion debate taps strongly held, powerfully experienced political and moral imperatives. These imperatives, in turn, are linked internally to a cluster of complex concerns and images evoking what sort of person one is and what one aspires to be. The abortion debate "doesn't seem to go away," nor should it. Man is after all, talking about matters of life and death, freedom and obligation, rights and duties. Society cannot dispute that, and society cannot be nonplussed when facing the dilemmas that the abortion question poses (Callahan & Callahan, 1984).

Abortion is a troubling topic which has provoked much conflict and controversy. Abortion is troubling since it is closely linked to individual world views and value systems. Each person seems to have a personal understanding of this issue. There will probably always be a long-standing issue on abortion since there are

opposing values displayed on both sides of the abortion debate. For example, people classify themselves as either prolife or prochoice.

Prolife

Prolife is an opinion that reflects the belief that abortion should never be an option to pregnancy because it involves the killing of a human being. People who classify themselves as "prolife" oppose abortion and view it as involving the ultimate immorality--the taking of human life (Paige, 1983). Prolife supporters do not view abortion as a simple medical procedure and expect the coercive authority of government to forbid it. Prolife supporters believe the Supreme Court is misguided in providing constitutional protection for abortion.

This segment of the population generally accepts various prohibitions on federal spending for abortion as short-run success and looks to a total prohibition of abortion as the ultimate success. The prolife supporters denounce abortion and emphasize the "right to life" (Steiner, 1983).

Prochoice

Prochoice is an opinion that reflects the belief that abortion is a woman's choice as an option to pregnancy. People who classify themselves as "prochoice" support the 1973 Supreme Court decision which ruled that a woman's constitutional right to privacy includes her right to decide, in consultation with her physician, whether or not to terminate her pregnancy (Steiner, 1983).

Prochoice supporters of legalized abortion deny the premise that abortion is the taking of life and so implicitly dismiss the immorality indictment regarding this issue. These supporters view abortion as a private medical procedure that a woman may choose to undergo or to reject (Reardon, 1987).

Prochoice supporters support the private character of abortion and look toward universal "freedom of choice" as the ultimate goal. Regardless of how people classify themselves in terms of the abortion debate, there is much concern about an increased rate of repeat abortion.

Repeat Abortion

Repeat abortion is an action which involves having

the abortion procedure performed more than one time. Repeat abortion is defined as having had more than one abortion (Lake, 1980). Repeat abortion is being reported with increasing frequency in the United States and the percentage of repeat abortion has increased since abortion became legal.

Even though there is no single answer, there are a number of explanations as to why the rate of repeat abortion keeps rising. Some of these explanations are: (a) women are more sexually active; (b) inadequacy of birth control methods because of failure to use them or method failure; (c) women feeling uncomfortable about planning in advance for the possibility of having sexual intercourse; and (d) contraceptive risk-taking theory proposed by Luker (1975) which viewed women as being engaged in a dynamic human process in which not using contraception sometimes becomes more rational than using it (Lake, 1980).

There are many who feel that abortion is unacceptable as a primary method of birth control and should only be used as a backup measure when contraception has failed. There are those who fear that multiple abortions cause minor adverse effects on the

health of the woman or there are later effects on pregnancies (Tietze, 1978). Health workers and counselors who provide abortion services sometimes perceive themselves as failing to properly educate clients to successfully use contraceptive methods when clients return to repeat the abortion procedure (Tietze & Bongaarts, 1982).

There are many values which trigger society's emotional reactions to repeated abortion. Negative attitudes toward the repeated abortion client spring from the Western value system and an interpretation of what abortion means. There has been an effort to gain understanding of the increase in high rates of abortion by examining contraceptive risk-taking behavior.

Sexual intercourse without the fear of pregnancy may be within the grasp of women through the use of contraceptives. Yet, there are times when women may shirk that responsibility and take a risk by having sexual intercourse without some form of birth control (Cassell, 1984).

Review of Related Literature

Risk-Taking Behavior. Risk-taking behavior is

defined as behaviors which may cause hazard, peril, or jeopardy to a person. For example, cigarette smoking causes hazard to one's health and can be considered a risk-taking behavior. The process of living can be viewed as a series of calculated risks.

While making decisions, people typically weigh the alternatives, assign values to various choices, calculate the foregone opportunities in each choice, and then ultimately decide which of the options available they will choose. These choices are not always explicitly or clearly articulated. In perhaps the majority of life situations, this calculation of the "risks of life" is a subtle, intuitive, continuing process (Luker, 1975).

Luker (1975) has used a model of classical decision-making theories to explain contraceptive risk-taking. For example, it is assumed that individuals perceive options, assign values to these various options. Finally, they choose one option that is preferable to another. They then act to implement that choice in terms of their behavior.

This model was used to argue that women who do not use contraceptive methods such as prescriptive and nonprescriptive methods in order to protect themselves

from pregnancy are nevertheless women who in fact have engaged in a "rational" decision-making process (in a goal-directed sense of the word). This process consists of a series of decision junctures where the women assigns values to certain variables such as risk-taking and the probability of pregnancy and options to pregnancy. Their behavior is based on these assigned values.

This model was used to examine the decisions made by non-contraceptive using women. It was hindered because women almost always decided to take a non-contraceptive using risk before they became pregnant, while thinking that it was unlikely that they would become pregnant.

Luker (1975) has contended that risk-taking women are constantly in the process of bargaining with themselves to determine the costs and benefits of contraceptive use, the possibility and costs and benefits of pregnancy, and the likelihood that pregnancy will occur. Contraceptive risk-taking is a dynamic process, the end product of a chain that is constantly being reassessed in light of new information that arises regarding the outcome of the risk-taking.

Luker (1975) has suggested that contraceptive risk-taking is a decision-making process in which all women are engaged, although many women do not follow the process all the way to a risk-taking conclusion. All sexually active women are potential risk-takers regarding contraceptives since the immediate human cost of using contraception is weighed against the remote and uncertain cost of unwanted pregnancy.

As women take risks over time without any immediate consequence, there are two things that typically happen. First, women abandon their caution regarding the contraceptive they were using, undertake multiple risks or omit the contraception they were using. Second, as women "get away with" risk-taking behavior by not getting pregnant, over time they assume that not getting pregnant is something intrinsic to them. This leads to women continuing to take such risks (Luker, 1975).

Luker (1975) has cited several factors which contribute to contraceptive risk-taking. These factors are:

1. Age of the woman. For example,the older the woman is the less careful she is in terms of using contraceptives.

2. Relationship to the sexual partner. For example, women who have less quality in their relationship according to personal feeling about the relationship, are less careful using contraceptives.

3. Living arrangements with the sexual partner. Women who live with their sexual partners are less careful with using contraceptives.

4. Impending prospect of divorce or breakup of a relationship. Women who have relationships that are close to divorce or breakup are less careful with using contraceptives.

Luker (1975) has also found several "life events" that were characteristic of women interviewed, but not directly connected with contraceptive risk-taking. These events were: (a) death of a significant other, (b) a sibling experiencing a problem pregnancy, (c) life crises and times of transition, and (d) dissatisfaction with one's job or career.

Sexuality

Sexuality is defined as the quality or state of being sexual, the condition of having sex, or expressing of sexual receptivity or interest (McKinney & Sprecher,

1989). There has been a change in women's sexual behavior whereas some women are demanding full sexual equality and enjoyment. Women now initiate and feel they have a right to sexual satisfaction. There is knowledge that the female sex drive is as strong as the male's and awareness that society has been increasingly affirming women's rights to be as sexually emancipated as men (Clinebell, 1973).

Women today seem to have fallen into a tangle of failed relationships, sexual misapprehension and general discontent. There is an abyss between women's expectations and realities since women usually expect more in a sexual relationship than what they receive in reality. Despite the sexual revolution, the pill, slogans of sisterhood, and media assurance of "we've come a long way," women are still not sexually free (Cassell, 1984).

There is a central fact of female sexuality that all too often means women deny responsibility for their sexuality. A lot of women wrap their desire in a cloak of romance and need "love" in order to have sex. This desire is the demand to be swept away in romance.

Swept away is a sexual strategy, a coping mechanism, which allows women to be sexual in a society that is still ambivalent about and at times, condemnatory of female sexuality. Swept away is a tactic, employed unconsciously by women to get what they want, for example, a man or sexual pleasure, without having to pay the price of being labeled wanton or promiscuous. Swept away is, consequently, a counterfeit emotion, a fraud, a disguise of women's true erotic feeling which women have been socialized to describe as romance (Cassell, 1984).

Therefore, women have to acknowledge that they are sexual people and that they are planning to have sexual intercourse. It seems that one strong reason women continue to get pregnant when they don't want to be, when they know about contraception, and when methods are available is their traditional training as "good girls."

Women become ambivalent, anxious, and vulnerable about their sexual selves which may keep them off-balance. For example, they want to have sexual intercourse emotionally and physiologically. They also want to be loved and respected by the men they are involved with. Women have been taught that fulfilling

their physical needs deprives them of their worthiness of love. Therefore, women deny the potential for sexual encounters, then indulge in sexual intercourse unpreparedly and get pregnant (Cassell, 1984).

There remains uncertainty and confusion concerning female sexuality. Thus, it may be expected that many women will not adopt a rational means/end orientation toward the problem of avoiding unwanted pregnancy. The control which is called for in terms of a good appraisal of female sexuality plus acceptance of oneself as both sexually active and at risk of pregnancy would be difficult for those who have not yet come to terms with the changes of sexuality in the Western society.

Quality of Sexual Relationship

Sexual relationships are defined as relationships between people that involve the expression of sexuality (McKinney & Sprecher, 1989). Relationships are a very important aspect in the lives of most people. A deep relationship is one in which two people develop a feeling of closeness. This closeness is defined as having mutual understanding, awareness, rapport, communion, and a feeling of oneness or togetherness. A shallow

relationship, on the opposite hand, would be a relationship that is distant, superficial, trivial, insignificant, and empty of meaning. People lack understanding of each other's innermost feelings and thoughts in a shallow relationship (Greenfield, 1984). Therefore, these relationships may be called romantic, but are unreal.

Of late, there has been a new openness toward sexual matters and discoveries about sexuality such as easier and safer birth control methods which helped myths about women and sex on the one hand and worries about pregnancy on the other. These two major changes have shed a new light on male-female sexual relationships (Feldman & Parrot, 1984).

Many women and men are finding that in a relationship of equality, liberated sex is possible and both partners can luxuriate in what feels natural, good and satisfying for both people involved. Men and women can express their sexual needs to each other without fear of being too aggressive or too demanding (Clinebell, 1973).

On the other hand, there are still males and females who do not have an open sexual relationship due to a

double standard of thinking about who can enjoy sex and who can't. These feelings stem from values and attitudes that have developed through society. These sexual values affect the quality of relationship between sexual partners (Greenfield, 1984).

Attitudes Toward Children

The maternal instinct assumes that women are biologically endowed with a desire to have children. The fact that women have a reproductive system which enables them to bear children is probably what makes women think motherhood is a natural female drive, a drive to comply with their physiology. There is a complex socialization process which teaches females their proper roles. This involves attitude shaping, personality structuring, and a myriad of other conditioning factors that eventually result in what society thinks of as normal female behavior.

The fact that females have the physical capability to reproduce sometimes makes people feel that they must reproduce. This is the maternal instinct which may not be the answer. With regard to contemporary non-traditional thinking, there is nothing instinctual about

a woman wanting a child and it is just as natural for her to be a childless business woman as it is for her to be a mother and housewife (Silverman & Silverman, 1971).

Society, not nature, programs women to desire motherhood. From their earliest years until the time they marry or have children, women are inundated with socio-cultural pressures that make motherhood appear to be a natural aspect of their femininity.

There remains considerable questions as to whether there is such a thing as maternal instinct at all. Fine (1985) has argued that maternal instinct is a myth because no universal and absolute conduct on the part of the mother has emerged. Some women have a natural wish to bear children, while on the other hand, others can display terrible cruelty toward their children.

Women have the biological equipment to bear children and there are times when they bring children into the world. These women may not know how to care for children, teach them, feed them, help them, listen to them, learn from them, or love them. Having children often requires qualities such as patience, time, skill, flexibility, stamina, good will, and loving kindness, to name a few possible factors of parenting. Most of all,

having children involves a strong desire to do the tasks of parenting in order to nurture another human being into well-being in our society (Bozarth, 1987).

Yet, many women simply do not want children at the present time or in the future for their own personal reasons. These reasons can be as selfish and as unselfish as another woman's reasons for wanting children might be (Bozarth, 1987). Therefore, it must be recognized that there is also a wide picture of maternal hostility toward children which includes actual infanticide, beating, neglect, and many other forms of child abuse. The present study will now examine studies regarding risk-taking behavior, sexuality, quality of sexual relationships, and attitudes toward children.

Review of Related Research

Risk-Taking Behavior. Crosbie and Bitte (1982) sought to design a study to provide a test of Luker's (1975) theory among a more contraceptively varied population since Luker (1975) drew her theory from a small sample of contraceptive risk-takers.

The general purpose of this research was to test Luker's (1975) theory. The research was conducted in two

stages. The first stage was designed to identify a set of relatively independent contraception and pregnancy outcomes. The second stage was intended to test Luker's (1975) theory or model.

The researchers administered a questionnaire to a nonrandom sample of 567 female and male junior college and college students. A subsample of 221 females from the original sample indicated that they had been sexually active in the past four weeks and that they were not currently pregnant. The results of this study focused on the subsample.

There were six background variables reported in this research study. These variables were loosely categorized into three variable clusters: (1) Personal, (2) Parental, and (3) Relational.

Eight Personal variables were designed to assess characteristics of the individual that might be relevant to contraceptive and pregnancy considerations. Three Parental variables were designed to assess the respondent's status and intent regarding parenthood. Five Relational variables were designed to assess aspects of the respondent's relationship with the opposite sex in general and with her sexual partner in particular.

The data supported Luker's (1975) contention that the utilities for contraception and pregnancy were significantly determined by the individual's relevant background characteristics. It was found that the lower the perception or subjective probability of pregnancy without contraception, the greater the frequency of risk-taking behavior as Luker (1975) had hypothesized.

Luker (1975) argued that in contraceptive risk-taking, each successful risk substantiates the idea that the woman can get away with not getting pregnant indefinitely. The data from this research did not support this position. There was no relation between the measure of past success or failure at contraceptive risk-taking and the subjective probability of pregnancy without contraception.

The analysis of data for the currently active females in the sample failed to satisfactorily support the theory. The theory was correct in identifying background variables of the subjects.

However, Luker's (1975) theory was found to be simply and clearly inadequate to explain contraceptive risk-taking behavior. This research confirmed the results of other studies that identified the subjective

probability of contraceptive risk-taking behavior. These results were directly in reference to Luker's theory of contraceptive risk-taking and the study sought to test this theory (Crosbie & Bitte, 1982).

Sexuality

Sexual self-concept is defined as an individual's evaluation of his or her own sexual feelings and actions (Winter, 1988). Sexual self-concept is proposed as an important predictor of contraceptive behavior. One factor that obviously could interfere with using contraceptives, especially among adolescents, is guilt or their negative feelings about sex. Winter (1982) proposed a concept that an identifiable factor that influences contraceptive use is the evaluation of one's sexuality, instead of feelings about sexuality in general.

A scale was developed by the researcher to measure sexual self-concept to predict contraceptive behavior (Winter, 1988). The researcher met with 15 junior and senior high school students. The problem of teenage pregnancy and nonuse of contraceptions was discussed. These problems reflected four general areas: feelings

about having sexual intercourse; feelings about obtaining and using contraceptives; discussions about sex and contraception; and evaluation of one's sexual development. The researcher had 19 college students also contribute items which were intended to measure sexual self-concept.

The subjects in this sexual self-concept study were 120 male and female ninth and twelfth graders at a high school and 149 unmarried male and female undergraduate students. All students completed the sexual self-concept scale and undergraduate students also gave information about personal use of contraceptives. The high school students ranged in age from 14 to 19 years old and undergraduate students ranged in age from 17 to 23 years old. There were no differences found in terms of gender for scores on the sexual self-concept scale. However, students differed on the sexual self-concept scale in regards to age, with the older students scoring higher on the scale than the younger students. These findings indicated that sexual self-concept appeared to improve with age and suggested that younger teenagers may be poorer users of contraceptives because of a lower sexual self-concept.

The results of this study indicated that the older participants in the study had a more positive sexual self-concept than the younger participants in the study. Therefore, this study demonstrated that students who had used prescription contraceptive methods (i.e., oral contraceptives and diaphragm) had the highest scores on the sexual self-concept scale; followed by those who had used nonprescription contraceptive methods (i.e., condoms and foam), as compared to the withdrawal method (i.e., male withdraws before ejaculation) group and the group who had used no method.

This study indicated that sexual self-concept was strongly correlated with contraceptive behavior and sexual self-concept generally increases with age. It was suggested that counseling and self-education may improve contraceptive practice by addressing an individual's feelings about their sexuality.

Fertility control could be explored within the wider context of sexuality in order to incorporate all aspects of its problematic nature. In Western society, expressions of female sexuality are not allowed due to male control of sexuality. Women have been described as passive and having a non-interest in sex. This has led

to inaccurate beliefs concerning female sexuality as expressed in its predominant image of looking at women in terms of motherhood versus promiscuity. The crucial point is that the fulfillment of womanhood is often seen as motherhood where the woman is usually defined in terms of her biological potential to bear children (Oakley, 1972).

Woodhouse (1982) attempted to uncover the complex web of factors which often culminate in unwanted pregnancy. The researcher felt it was necessary to go beyond questioning young women about their attitudes of sexuality and contraception to find out exactly how and why they became pregnant.

Woodhouse (1982) interviewed young, single women who were having abortions at clinics run by charitable agencies. Sexual politics is defined as the extent to which relationships between men and women reflect and maintain wider social structures of a political nature (Woodhouse, 1982). The purpose of the research was to investigate unwanted pregnancy from the standpoint of sexual politics.

The incidence of pregnancy for the participants in the study was reported as not being the result of simple

carelessness but stemmed from their experience of various factors. Some of these factors lay outside of the participants' direct control, as in the cases of contraceptive method failure. Other factors depended on the individual's subjective interpretation.

The results indicated that participants did not talk much about contraception with their sexual partners and felt it was embarrassing to discuss this issue with them. The participants had a fear of being viewed as promiscuous, and there was little evidence of seeing sex as fun or for pleasure. Instead, sex was viewed as part of a love relationship. The stress was placed on the necessity for a steady relationship to develop prior to a sexual relationship.

This research demonstrated that the barriers to efficient contraceptive practice by young single women are multiple. The nature of sexual politics contribute to uncertainty and confusion concerning young single women's perception of their sexuality. It seems that efficient contraceptive practice will require a positive view of self as controlling one's sexuality and fertility.

Quality of Sexual Relationship

The quality of the relationship between sexual partners has often been examined in studies of women having abortions. For example, Brewer (1977) sought to examine women who have had three abortions or more to determine the factors involved with women repeating abortion three or more times.

The researcher attempted to interview every woman admitted to British clinics for a third or subsequent abortion. The patients were interviewed directly when possible, and by telephone if the interviews in person were inconvenient. The subjects were the first 50 women that were seen in the British clinics during 1977.

The results indicated that a number of abortions might have been avoided if these women had obtained other and better contraceptive methods than the ones they were currently using. None of the women in the study appeared to be using abortion as a method of birth control. There was a significant relationship between erratic use of contraceptives and a history of medical consultation for psychiatric reasons. This study suggested that unsettled relationships as indicated by the women between them and

their sexual partner and women with a low educational status are also related to erratic contraceptive use.

Aquirre (1980) sought to examine the effects of marital status on repeat abortion. The researcher collected information for the study from a private clinic. The sample consisted of 1,091 patients. Aquirre (1980) examined selected demographic characteristics of the patients, measures of social support for them to abort, their attitudes toward abortion, ambivalence to the abortion, source of idea of the abortion, referral source, and the contraceptive method used immediately prior to the abortion. The researcher divided the repeat abortion patients into three groups: single, married, and divorced women.

The results indicated that repeat abortion was high among married but quite low for divorced subjects. The patients with the greater number of live births that were in the married and divorced groups had a lower prevalence of abortion among them.

This study emphasized causal factors other than contraceptive use and recognized the importance of cultural values and social practices which tend to regulate man-woman relations. The researcher suggested

that it was important to examine in-depth life and family histories of men and women at all stages of couple relationships to understand the use of repeat abortion.

Niemela, Lehtinen, Rauramo, Hermansson, Karjalainen, Maxi, and Stora (1981) were concerned with the reasons why women having repeat abortion fail to prevent a new pregnancy and seek another abortion. The research sample consisted of 30 repeat abortion patients (i.e., women coming to the hospital for a second abortion). This sample was compared to 29 women who had one abortion and had successfully avoided conception for four years. These subjects were compared in terms of personality and current life situation and conditions (i.e., parents dead or divorced and economic situation in the childhood home) during their former years.

The subjects were given interviews which included the following areas: socioeconomic factors and family relationships of the childhood home, relationships with men, sex life, contraception, subjective description of present life situation, and the subjective feelings about the first and second abortion.

The results indicated that women who had repeat abortions were younger and had experienced life

situations considered less stable than that of the women who had one abortion only. The educational level and income was similar for both groups. The repeat abortion subjects had more often lost a parent, had larger families, and had other siblings from their parents' other relationships.

No differences were found between the repeated abortion group and the one time abortion group in terms of marital status. However, in terms of the duration of the current relationship, the one time abortion group had longer lasting relationships.

The women in the repeat abortion group had a history of broken legalized or non-legalized partner relationships more often. Therefore, it would appear that quality of sexual relationship between sexual partners is an important factor in examining repeat abortion patients. This study indicated that the women needing a second abortion were unable to improve their contraceptive practice as a result of labile life conditions, immature personality structures and the lack of support from partners and relatives.

Attitudes Toward Children

There are many research studies on children from different perspectives (i.e., child development, abuse, neglect, etc.). However, there appears to be a paucity of research which has addressed attitudes toward children in relation to repeat abortion patients.

Attitudes toward children are considered important because of the opposite views toward children such as maternal instinct and maternal hostility. Some women have a natural desire to have children and parenting is an aspect of life they want and enjoy. On the other hand, there are women who have a different maternal attitude and many abuse or neglect their children as a result of this attitude toward children.

Need for Study

There continues to be a general concern about the reasons why women have repeat abortions. This study was designed to provide further understanding of why women have repeat abortions by examining demographic characteristics and four factors that were hypothesized to be an aspect to be considered when studying repeat abortion patients. These four factors were: (a) risk-taking behavior, (b) sexuality, (c) quality of sexual

relationship, and (d) attitudes toward children. Consequently, this study served to add to the information regarding aspects of repeat abortion patients.

Purpose of the Study

The purpose of this study was to present a profile of characteristics of women who have had repeat abortions. A secondary purpose was to describe the risk-taking behavior, sexuality, quality of sexual relationships, and attitudes toward children of a selected group of women who had repeat abortions.

Study Hypotheses

There were four hypotheses used in this study. They were as follows:

Hypothesis One: The majority of survey respondents will rate themselves high on risk-taking behavior.

Hypothesis Two: The majority of survey respondents will report being uncomfortable with their sexuality.

Hypothesis Three: The majority of survey respondents will report being uncomfortable

with the quality of their present sexual relationship.

Hypothesis Four: The majority of survey respondents will report having a poor attitude toward children.

CHAPTER II

Methodology

Survey research techniques were used as the method for obtaining data for this research study. The research period commenced April 12 - May 14, 1990. Methods of the study are detailed below.

Site/Setting

The site for the research study was Atlanta, Georgia. Atlanta is the largest city in the Southeast and is the tenth largest city in the United States. The Atlanta metropolitan area is comprised of 18 counties with a population of 2.7 million. The minority population of the Atlanta metropolitan area is 25 percent (Atlanta Chamber of Commerce, 1990). This site was chosen because of its accessibility to the researcher.

The setting for the study was the XYZ-Care Surgery Center, a private clinic located in Atlanta, Georgia. XYZ-Care Surgery Center is a fully staffed and equipped state licensed facility dedicated exclusively to the special needs of outpatient surgery.

XYZ-Care Surgery Center performs abortions on women who are seven to nineteen weeks pregnant in the clinic (i.e., on the premises). The following services are also provided by staff counselors:

a. counseling services for help with feelings and concerns related to pregnancy and potential abortion;
b. information about the abortion itself such as risks due to complications;
c. information about birth control methods;
d. decision-making counseling and post abortion counseling on a short-term basis;
e. individual, couple and/or small group counseling; and
f. counseling to friends, partners and/or relatives accompanying women to the clinic.

Subject Pool/Sample

The subject pool in this study consisted of those women entering XYZ-Care Surgery Center during the

research period. These women were in their first trimester (seven to twelve weeks) of pregnancy and were seeking an abortion.

The sample consisted of 57 women from the subject pool who reported having had at least one abortion and were willing to participate in the study by completing the survey.

Research Team

The research team consisted of the principle investigator and the counselors of the XYZ-Care Surgery Center. Rules and responsibilities are detailed below.

Principle Investigator. The principle investigator was responsible for conducting all phases of the research. The principle investigator was also responsible for training other research team members (i.e., XYZ-Care Surgery Center staff counselors).

Counselors. The counselors were Masters level counselors licensed to practice in the State of Georgia. The counselors' responsibilities were to provide support and counseling services to the patients. Those persons who were employed in the capacity of part-time and full-

time staff counselors at XYZ-Care Surgery Center served as the research team members. There were four counselors who were so employed.

In recognition of their important role in this study, the principal investigator met with staff counselors prior to the inception of this study to ensure staff counselors familiarized themselves with the survey and survey items.

The purpose of this meeting was to train the counselors so they would know how to answer any questions the survey respondents might have regarding the study. In addition, they were familiarized by the principal investigator with the survey itself in order to respond correctly to any questions that arose regarding the survey. Finally, they reiterated to the survey respondents guarantees of confidentiality and anonymity while they also explained that participation in the study would in no way affect abortion services.

Instrumentation

The instrument utilized for this study was the Pre-Abortion Counseling Survey (PACS) (see Appendix A). The PACS was designed by the researcher for this study. The

PACS was designed to be self-administered. It was pilot tested for face and content validity. Modifications were then made as needed.

The survey contained a demographic section and also had four other dimensions. They were: risk-taking behavior, sexuality, quality of sexual relationship, and attitude toward children. In addition, there were 71 items which were close-ended questions. The instrument is described below:

Section A: Demographics: The demographic section has 25 close-ended items which served to provide the researcher with characteristics of the sample group. Demographic items include: age, ethnic group, highest educational level achieved, religious preference, degree of religiosity, employment status, annual income, marital status, political preference, number of children, number of previous abortions, cohabitating status, frequency of sexual intercourse, facts of life knowledge, and information concerning use of contraceptive methods.

Section B: Risk-Taking Behavior: This section has eight close-ended items which examined behaviors that are

are generally associated with risk-taking. Survey respondents responded to a four item Likert-type scale which consisted of the following possible responses: never, frequently, sometimes, or always.

Score values assigned to these items were as follows: A never response received a score value of one, a sometimes response received a score value of two, a frequently response received a score value of three, and an always response received a score value of four.

Section B: Scoring: A total score value of 0-21 indicated that the typical survey respondent tended to strongly disapprove/disapprove of the risk taking behaviors that are listed on Section B of the PACS. Meanwhile, a total score value of 23-32 indicated that the typical survey respondent tended to approve/strongly approve of the risk taking behaviors that are listed on Section B of the PACS.

Section C: Sexuality: This section had 17 close-ended items which were designed to examine the degree to which survey respondents were comfortable with their sexuality. Survey respondents chose from two sets of responses on a four item Likert-type scale which were:

strongly disagree, disagree, agree, or strongly agree; and never, sometimes, frequently, or always.

Score values assigned to these items are as follows: A strongly disagree or never response received a score value of one; a disagree or sometimes response received a score value of two; an agree or frequently response received a score value of three; a strongly agree or always received a score value of four.

Section C: Scoring: A total score value of 0-42 indicated that the typical survey respondent was very uncomfortable/uncomfortable with the sexuality issues listed on Section C of the PACS. Meanwhile, a total score value of 43-68 indicated that the typical survey respondent was very comfortable/comfortable with the sexuality issues listed on Section C of the PACS.

Section D: Quality of Sexual Relationships. This section has 11 close-ended items which were designed to measure survey respondents' rating of the quality of their relationship with their sexual partner(s). Survey respondents responded to a four item Likert-type scale which consisted of the following: strongly disagree, disagree, agree, or strongly agree.

Score values assigned to these items were as follows: A strongly disagree response received a score value of one; a disagree response received a score value of two; an agree response received a score value of three; and a strongly agree response received a score value of four.

Section D: Scoring. A total score value of 0-27 indicated that the typical survey respondent was very uncomfortable/uncomfortable with the quality of her sexual relationship based on the quality of sexual relationship items listed on Section D of the PACS. Meanwhile, a total score value of 28-44 indicated that the typical survey respondent is very comfortable/ comfortable with the quality of her sexual relationship based on the quality of sexual relationship items listed on Section D of the PACS.

Section E: Attitudes Toward Children. This section has ten close-ended items which examined survey respondents' attitudes toward children. Survey respondents responded to a four item Likert-type scale which consisted of the following: strongly disagree, disagree, agree, or strongly agree.

Score values assigned to these items were as follows: A strongly disagree response received a score value of one; a disagree response received a score value of two; an agree response received a score value of three; and a strongly agree response received a score value of four.

Section E: Scoring. A total score value of 0-25 indicated that the typical survey respondent had a very poor/poor attitude toward children as indicated by the attitude toward children items listed on Section E of the PACS. Meanwhile, a total score value of 26-40 indicated that the typical survey respondent had a very good/good attitude toward children as indicated by the attitude toward children items listed on Section E of the PACS.

Procedures

There were three research periods utilized in this study. They are the pre-research, research, and post-research periods. These research periods are detailed below along with procedures for each period.

Pre-Research Period

Procedure 1. The researcher contacted the director of XYZ-Care Surgery Center regarding participation as a research site by telephone and in person.

Procedure 2. A letter was sent from the researcher to the director concerning the time, date, and purpose of the research (see Appendix B).

Procedure 3. A follow-up letter was sent from the researcher to the director after the meeting which included an administrative agreement (see Appendix C and D). The administrative agreement listed agreements made by the director and principal investigator regarding the study.

Procedure 4. The director informed the XYZ-Care Surgery Center staff counselors in person of her agreement for them to participate in the study and to be trained by the principal investigator for their roles in the study.

Procedure 5. The principal investigator called the staff counselors by telephone and set a meeting time for the training session. At this meeting, the principle investigator informed the staff counselors of the purpose of the research, their

role in the research, and familiarized them with the survey. The principal investigator trained these counselors to examine the survey to ensure that survey respondents have completed all survey items.

Research Period

Procedure 6. Clients were seen by the XYZ-Care Surgery Center counselors as part of the typical procedure of the clinic. The counselors explained the purpose of the research to these clients.

Counselors then asked the clients if they were willing to complete the survey. Survey respondents were given assurance of anonymity and confidentiality and also told that their decision to participate would not interfere with counseling and abortion services.

If clients agreed to participate in the study, they were given a PACS and asked to complete it. Also, survey respondents (i.e., those choosing to participate in the study) received counseling and abortion services after the survey was completed.

If clients expressed their unwillingness to participate, staff counselors continued to provide XYZ-Care Surgery Center services.

Procedure 7. As part of the typical procedure of the clinic, the staff counselors then provided instructions and distributed the PACS to the survey respondents. After the survey respondents examined the PACS, staff counselors asked the survey respondents if they had any questions concerning the survey. If there were questions, the staff counselors assisted survey respondents in answering these questions.

Procedure 8. After the survey respondent returned the completed survey to the staff counselors, they examined the survey to ensure that it had been fully completed by the survey respondent.

If the survey respondent had not completed all the survey items, the staff counselors verbally asked them to complete the survey. The staff counselors also assisted with any other questions posed at this time by survey respondents regarding the PACS and/or the study.

Procedure 9. The counselors stored the completed surveys in a safe place for later collection by the principal investigator.

Procedure 10. These procedures were completed until all surveys were collected.

Post-Research Period

Procedure 11. The study was then terminated.

Data Collection

All data were collected by the principal investigator.

Data Analysis

Statistical procedures utilized for this study were Frequency Analysis in numbers and percentages.

Human Subjects Contract

Human subjects contracts were not necessary because subjects were not receiving any treatment. The subjects were not exposed to any physical or mental harm due to participation in the study. They were given verbal guarantees by staff counselors of anonymity and confidentiality. Further, they were assured that

participation in the study would not affect counseling and abortion services.

Table 2.0

Procedures, Activities, Forms, Letters and Training Utilized During the Pre-Research, Research and Post-Research Periods

Period	Procedures	Forms/Letters	Training
Pre-Research Period	1) Principal investigator contacted director of XYZ-Care Surgery Center. 2) Director informed staff counselors of their participation and training regarding the study. 3) Principal investigator contacted staff counselors of XYZ-Care Surgery Center.	Letter, follow-up letter and administrative agreement sent by the principal investigator to the director (see Appendices B, C, and D).	Principal investigator trained staff counselors of XYZ-Care Surgery Center.
Research Period	1) Staff counselors asked clients to complete the survey. 2) Staff counselors gave the PACS survey to survey respondents. 3) Surgery repondents completed PACS survey.	N/A	N/A
Post-Research Procedure	All data collected. Study terminated.		

CHAPTER III

Results

The primary purpose of this study was to present a profile of characteristics of women who have had repeat abortion. A secondary purpose was to describe the risk-taking behavior, sexuality, quality of sexual relationships, and attitudes toward children of a selected group of women who had repeat abortions. Results for this study were divided into five sections: Section A, B, C, D, and E.

Section A details results gathered from demographics from the Pre-Abortion Counseling Survey. The demographics section contained 15 variables.

Section B contains results regarding the level of survey respondents' risk-taking behavior. Results are assessed based on Hypothesis One.

Meanwhile, in Section C, results are assessed based on Hypothesis Two. As such, information gathered reports the findings of the respondents' level of comfortability with their sexuality.

Section D contains results regarding the quality of

the respondents' sexual relationship. These results are related to Hypothesis Three.

Section E is related to Hypothesis Four. Information gathered measures the respondents' attitudes toward children. Results from each section are detailed below.

Section A: Demographic Data

Demographic data included fifteen variables. They are: age, ethnic group, highest educational level achieved, religious preference, degree of religiosity, employment status, annual income, marital status, political preference, number of children, number of previous abortions, cohabitating status, frequency of sexual intercourse, facts of life knowledge, and information concerning use of contraceptive methods. Results are detailed below.

Age

As shown in Table 3.1, of 57 survey respondents, nine (or 15.8 percent) were between 16-20 years of age; 17 (or 29.8 percent) were between 21-25 years of age; 16 (or 28.1 percent) were between 26-30; 10 (or 17.5 percent) were between 31-35 years of age. Meanwhile, four (or 7 percent) were between 36-40 and one (or 1.8

Table 3.1

Frequency Analysis: Age, Ethnicity, Highest Educational Level Achieved, Religious Preference, and Degree of Religiosity in Numbers (#) and Percentages (%) (N=57)

Age	#	%	Ethnic Group	#	%
16-30	9	15.8	Black	27	47.4
21-25	17	29.8	White	26	45.6
26-30	16	28.1	Asian	2	3.5
31-35	10	17.5	Hispanic	1	1.8
36-40	4	7.0	Other/American		
Over 40	1	1.8	Indian	1	1.8
Total	57	100.0	Total	57	100.0

Highest Educational Level Achieved	#	%	Religious Preference	#	%
High School	10	17.5	Baptist	33	57.9
Some College	21	36.8	Methodist	5	8.8
AA/AS Degree	4	7.0	Presbyterian	4	7.0
BA/BS Degree	15	26.3	Episcopal	4	7.0
MA/MS Degree	7	12.3	Catholic	6	10.5
			Other	5	8.8
Total	57	100.0	Total	57	100.0

(table continues)

Table 3.1 (continued)

Degree of Religiosity	#	%
Frequently	18	31.6
Sometimes	22	38.6
Seldom	13	22.8
Never	4	7.0
Total	57	100.0

percent) was 40 years of age or older. Therefore, the typical survey respondent was between 21-25 years of age.

Ethnic Group

As shown in Table 3.1, of 57 survey respondents, 27 (or 47.4 percent) were Black, 26 (or 45.6 percent) were White/Caucasian, and two (or 3.5 percent) were Asian. Meanwhile, one (or 1.8 percent) was Hispanic, and one (or 1.8 percent) was American Indian. Therefore, the typical survey respondent was Black.

Highest Educational Level Achieved

As shown in Table 3.1, of 57 respondents, 10 or (17.5 percent) had completed high school; 21 (or 36.8 percent) had some college education; and four (or 7 percent) had obtained an AA/AS degree. Meanwhile, 15 (or 26.3 percent) had obtained a BA/BS degree and seven (or 12.3 percent) had obtained a MA/MS degree. Therefore, the typical survey respondent had obtained some college education.

Religious Preference

As shown in Table 3.1, of 57 survey respondents, 33 (or 57.9 percent) listed Baptist as a religious preference; five (or 8.8 percent) listed Methodist; and four (or 7 percent) listed Presbyterian. Meanwhile, four (or 7 percent) listed Episcopal as their religious preference; six (or 10.5 percent) listed Catholic; and five (or 8.8 percent) indicated Other as their religious preference. Therefore, the typical survey respondent listed Baptist as their religious preference.

Degree of Religiosity

As shown in Table 3.1, of 57 survey respondents, 18 (or 31.6 percent) reported they frequently attended a

place of worship; and 22 (or 38.6 percent) sometimes attended a place of worship. Meanwhile, four (or 7 percent) reported they never attended a place of worship. Therefore, the typical survey respondent reported attending a place of worship sometimes.

Marital Status

As shown in Table 3.2, of 57 survey respondents, 33 (or 57.9 percent) were single/never married and 14 (or 24.6 percent) were married. Meanwhile, one (or 1.8 percent) was separated; while nine (or 15.8 percent) were divorced/widowed. Therefore, the typical survey respondent was single/never married.

Number of Children

As shown in Table 3.2, of 57 survey respondents, 29 (or 50.9 percent) had no children, while 28 (or 49.1 percent) had one or two children. Therefore, the typical survey respondent had no children.

Employment Status

As shown in Table 3.2, of 57 survey respondents, two (or 3.5 percent) were self-employed in the home; six (or 10.5 percent) were self-employed outside the home;

Table 3.2

Frequency Analysis: Marital Status, Number of Children, Employment Status, and Annual Income in Numbers (#) and Percentages (%) (N=57)

Marital Status	#	%	Children	#	%
Single, Never Married	33	57.9	None	29	50.9
Married	14	24.6	1-2	28	49.1
Separated	1	1.8			
Divorced/Widowed	9	15.9			
Total	57	100.0	Total	57	100.0

Employment	#	Annual Income	#	%
Self-Employed (Home)	2	No Income	4	7.0
Self-Employed (Outside Home)	6	$1-4,999	2	3.5
Employed	42	$5,000-9,999	2	3.5
Unemployed	4	$10,000-14,999	8	14.0
Part-Time	9	$15,000-19,999	13	22.8
Full-Time	31	$20,000-24,999	14	24.6
Total	94	$25,000-29,999	5	8.8
		$30,000-34,999	2	3.5
		$35,000-39,999	2	3.5
		Over $40,000	5	8.8
		Total	57	100.0

and 42 (or 73.7 percent) were employed. Meanwhile, four (or 7 percent) were unemployed; nine (or 15.8 percent) were employed part-time; and 31 (or 54.4 percent) were employed full-time. Therefore, the typical survey respondent was employed full-time.

Annual Income

As shown in Table 3.2, of 57 survey respondents, four (or 7 percent) reported having no income; two (or 3.5 percent) reported having an individual annual income ranging from $1-4,999; two (or 3.5 percent) had salaries ranging from $5,000-9,999; eight (or 14 percent) had salaries ranging from $10,000-$14,999; 14 (or 24.6 percent) had salaries ranging from $20,000-24,999; five (or 8.8 percent) had salaries ranging from $25,000-29,999. Meanwhile, two (or 3.5 percent) reported an annual income of $30,000-34,999; two (or 3.5 percent) had salaries ranging from $35,000-39,999; while five (or 8.8 percent) had salaries ranging over $40,000. Therefore, the typical survey respondent reported having an annual income of $20,000-$24,999.

Political Preference

As shown in Table 3.3, of 57 survey respondents, seven (or 12.5 percent) reported their political preference as conservative; 12 (or 21.4 percent) as moderate; 18 (or 32.1 percent) as liberal; and three (or 5.4 percent) as socialist. Meanwhile, nine (or 16.1 percent) were feminist; 26 (or 46.4 percent) were Democratic; four (or 7.1 percent) were Republican; 12 (or 21.4 percent) were independent, while 31 (or 55.4 percent) were pro-choice. Therefore, the typical survey respondent reported being a pro-choice Democrat.

Previous Abortions

As shown in Table 3.3, of 57 survey respondents, 30 (or 52.6 percent) reported having one previous abortion; 23 (or 40.4 percent) had two previous abortions, and four (or 7 percent) reported having three previous abortions. Therefore, the typical survey respondent reported having one previous abortion.

Cohabitating Status

As shown in Table 3.3, of 57 survey respondents, 24 (or 42.1 percent) reported living with their sexual partner at present, while 33 (or 57.9 percent) reported

Table 3.3

Frequency Analysis: Political Preference, Previous Abortions, Cohabitating Status, and Frequency of Sexual Intercourse in Numbers (#) and Percentages (%) (N=57)

Political Preference	#
Conservative	7
Moderate	12
Liberal	18
Socialist	3
Feminist	9
Democratic	26
Republican	4
Independent	12
Pro-Choice	31
Total	122

Previous Abortions	#	%
1	30	52.6
2	23	40.4
3	4	7.0
Total	57	100.0

Cohabitating Status	#	%
Yes	24	42.1
No	33	57.9
Total	57	100.0

Frequency of Sexual Intercourse	#	%
Not at All	1	1.8
1-3 Times a Week	33	57.9
4-7 Times a Week	10	17.5
Other	13	22.8
Total	57	100.0

they did not live with their sexual partner at present. Therefore, the typical survey respondent reported she was not living with her sexual partner at the present time.

Frequency of Sexual Intercourse

As shown in Table 3.3, of 57 survey respondents, one (or 1.8 percent) one reported not presently having sexual intercourse; 33 (or 57.9 percent) reported having sexual intercourse one to three times a week; and 10 (or 17.5 percent) four to seven times a week. Meanwhile, 13 (or 22.8 percent) indicated "other" when describing frequency of sexual intercourse. Therefore, the typical survey respondent reported having sexual intercourse one to three times a week.

Facts of Life Knowledge

As shown in Table 3.4, of 57 survey respondents, 34 (or 59.6 percent) reported they learned the facts of life from their mother/parent; eight (or 14 percent) from a relative; and 33 (or 57.9 percent) from friends. Meanwhile, 23 (or 40.4 percent) learned the facts of life from sex education through the school and six (or 10.5 percent) from sex education through the media. In addition, 18 (or 31.6 percent) reported they learned the

facts of life from a sexual partner and three (or 5.3 percent) from other sources. Therefore, the typical survey respondent reported they learned the facts of life from their mother/parent and friends.

Table 3.4

Frequency Analysis: How Facts of Life Were Learned in Numbers (#) and Percentages (%) (N=57)

Source	#	%
Mother/Parent	34	59.6
Relative	8	14.0
Friends	33	57.9
Sex Education-School	23	40.4
Sex Education-Media	6	10.5
Sexual Partner	18	31.6
Other	3	5.3
Total	125	219.3

Contraceptive Methods

A. Birth Control Pills

As shown in Table 3.5, of 57 survey respondents, 15 (or 26.3 percent) have experienced medical problems with birth control pills; eight (or 14 percent) reported they did not plan to use birth control pills; five (or 8.8 percent) were currently using birth control pills and 23 (or 40.4 percent) plan to use birth control pills. Therefore, the typical survey respondent reported she planned to use birth control pills as a contraceptive method.

B. Intrauterine Device (IUD)

As shown in Table 3.5 of 57 respondents, one (or 1.8 percent) reported they had experienced medical problems with the IUD; 44 (or 77.2 percent) reported they did not use the IUD and six or (10.5 percent) reported they planned to use the IUD. Therefore, the typical survey respondent reported she did not plan to use the IUD as a contraceptive method.

C. Diaphragm

As shown in Table 3,5, of 57 survey respondents, four (or 7 percent) reported they experienced medical

Table 3.5

Frequency Analysis: Contraceptive Methods in Numbers (#) and Percentages (%) (N=57)

Birth Control Pills	#	%	IUD	#	%
Medical Problems	15	26.3	Medical Problems	1	1.8
Do Not Plan To Use	8	14.0	Do Not Plan To Use	44	77.2
Currently Use	5	8.8	Currently Use	0	0.0
Plan to Use	23	40.4	Plan to Use	6	10.5
Multiple Response	5	8.8	Multiple Response	2	3.5
No Response	1	1.8	No Response	4	7.0
Total	57	100.0	Total	57	100.0

Diaphragm	#	%	Condoms	#	%
Medical Problems	4	7.0	Medical Problems	3	5.3
Do Not Plan To Use	38	66.7	Do Not Plan To Use	9	15.8
Currently Use	2	3.5	Currently Use	14	24.6
Plan to Use	4	7.0	Plan to Use	18	31.6
Multiple Response	5	8.8	Multiple Response	8	14.0
No Response	4	7.0	No Response	4	7.0
Total	57	100.0	Total	57	100.0

(table continues)

Table 3.5 (continued)

Cervical Cap	#	%	Birth Control Gel	#	%
Medical Problems	0	0.0	Medical Problems	1	1.8
Do Not Plan To Use	47	82.5	Do Not Plan to Use	38	66.7
Currently Use	1	1.8	Currently Use	1	1.8
Plan to Use	1	1.8	Plan to Use	6	10.5
Multiple Response	1	1.8	Multiple Response	2	3.5
No Response	7	12.3	No Response	9	15.8
Total	57	100.0	Total	57	100.0

Birth Control Foam	#	%	Contraceptive Sponge	#	%
Medical Problems	1	1.8	Medical Problems	1	1.8
Do Not Plan To Use	35	61.4	Do Not Plan To Use	36	63.2
Currently Use	4	7.0	Currently Use	5	8.8
Plan to Use	8	14.0	Plan to Use	5	8.8
Multiple Response	2	3.5	Multiple Response	4	7.0
No Response	7	12.3	No Response	6	10.5
Total	57	100.0	Total	57	100.0

(table continues)

Table 3.5 (contined)

Spermicidal Suppositories	#	%	Other	#	%
Medical Problems	1	1.8	Medical Problems	0	0.0
Do Not Plan to Use	43	75.4	Do Not Plan to Use	5	8.8
Currently Use	1	1.8	Currently Use	0	1.0
Plan to Use	4	7.0	Plan to Use	2	3.5
Multiple Response	0	0.0	Multiple Response	1	1.8
No Response	8	14.0	No Response	49	86.0
Total	57	100.0	Total	57	100.0

None	#	%
Medical Problems	0	0.0
Do Not Plan to Use	5	8.8
Currently Use	5	8.8
Plan to Use	1	1.8
Multiple Response	4	7.0
No Response	42	73.7
Total	57	100.0

problems with the diaphragm; 38 (or 66.7 percent) reported they did not plan to use the diaphragm; two (or 3.5 percent) reported currently using the diaphragm and four (or 7 percent) reported planning to use the

diaphragm. Therefore, the typical survey respondent reported she did not plan to use the diaphragm as a contraceptive method.

D. Condoms

As shown in Table 3.5, of 57 survey respondents, three (or 5.3 percent) reported having experienced medical problems with the use of condoms; nine (or 15.8 percent) reported they did not plan to use condoms; 14 (or 24.6 percent) reported currently using condoms; and 18 (or 31.6 percent) reported planning to use condoms. Therefore, the typical survey respondent reported she planned to use condoms as a contraceptive method.

E. Cervical Cap

As shown in Table 3.5, of 57 survey respondents, 47 (or 82.5 percent) reported they did not plan to use the cervical cap; one or (1.8 percent) reported currently using the cervical cap and one or (1.8 percent) reported planning to use the cervical cap. Therefore, the typical survey respondent reported she did not plan to use the cervical cap as a contraceptive method.

F. Birth Control Gel

As shown in table 3.5 of 57 survey respondents, one

(or 1.8 percent) reported they had experienced medical problems with birth control gel; 38 (or 66.7 percent) reported they did not plan to use birth control gel; one (or 1.8 percent) reported currently using birth control gel and six (or 10.5 percent) reported they planned to use birth control gel. Therefore, the typical survey respondent reported she did not plan to use birth control gel as a contraceptive method.

G. Birth Control Foam

As indicated in Table 3.5, of 57 survey respondents, one (or 1.8 percent) reported having experienced medical problems with birth control foam; 35 or (61.4 percent) reported they did not plan to use birth control foam; four (or 7 percent) reported currently using birth control foam and eight (or 14 percent) reported planning to use birth control foam. Therefore, the typical survey respondent reported she did not plan to use birth control foam as a contraceptive method.

H. Contraceptive Sponge

As shown in Table 3.5 of 57 survey respondents, one (or 1.8 percent) reported having experienced medical problems with the sponge; 36 (or 63.2 percent) reported

they did not plan to use the sponge; five (or 8.8 percent) reported currently using the sponge and five (or 8.8 percent) reported planning to use the sponge. Therefore, the typical survey respondent reported she did not plan to use the contraceptive sponge as a contraceptive method.

I. Spermicidal Suppository

As shown in Table 3.5, of 57 survey respondents, one (or 1.8 percent) reported having experienced medical problems with spermicidal suppositories; 43 (or 75.4 percent) reported they did not plan to use spermicidal suppositories; one (or 1.8 percent) reported currently using spermicidal suppositories and four (or 7 percent) reported planning to use spermicidal suppositories. Therefore, the typical survey respondent reported she did not plan to use spermicidal suppositories as a contraceptive method.

J. Other (Contraceptive Method)

As shown in Table 3.5 of 57 survey respondents, five (or 8.8 percent) reported they did not plan to use other forms of contraceptive methods; and two (or 3.5 percent) reported they planned to use other forms of contraceptive

methods. Therefore, the typical survey respondent who completed this item did not indicate other forms of birth control methods.

K. None (Contraceptive Method)

As shown in table 3.5 of 57 survey respondents, five (or 8.8 percent) reported they do not plan to use a contraceptive method; five (or 8.8 percent) reported currently using no contraceptive method; and one (or 1.8 percent) reported she did not plan to use a contraceptive method. Therefore, the typical survey respondent reported none as a contraceptive method.

Summary: Demographics Section

The typical survey respondent was Black and between 21-25 years of age. She was single, never married, had no children, and had obtained some college education. She was employed full-time and had an annual income of $20,000-24,999.

The typical survey respondent listed Baptist as her religious preference and reported she attended a place of worship sometimes. She listed her political preference as a pro-choice Democrat.

The typical survey respondent had one previous abortion, did not presently live with her sexual partner and engaged in sexual intercourse one to three times a week on the average. She learned the facts of life from her mother/parent and friends.

The typical survey respondent planned to use birth control pills and condoms in the future as her choice of contraceptive methods. Finally, she did not plan to use the IUD, diaphragm, cervical cap, birth control gel, birth control foam, contraceptive sponge, or spermicidal suppositories as contraceptive methods.

Section B. Risk-Taking Behavior

Hypothesis One stated that survey respondents would rate themselves high on risk-taking behavior. The risk-taking dimension was related to Hypothesis One and contained eight items which were items 26-33 on the PACS.

As shown in Table 3.6, when 57 survey respondents were asked to report if they smoked cigarettes, 30 (or 52.6 percent) never smoked cigarettes; 12 (or 21.1 percent) sometimes smoked cigarettes; nine (or 15.8 percent) frequently smoked cigarettes and six (or 10.5 percent) always smoked cigarettes. Therefore, the

Table 3.6

Frequency Analysis: Risk-Taking Behaviors in Numbers (#) and Percentages (%) (N=57)

Item 1			Item 2		
Smoked Cigarettes	#	%	Have Written on Public Property	#	%
Never	30	52.6	Never	46	80.7
Sometimes	12	21.1	Sometimes	11	19.3
Frequently	0	0.0	Frequently	0	0.0
Always	0	0.0	Always	0	0.0
Total	57	100.0	Total	57	100.0

Item 3			Item 4		
Wore Seatbelts When Riding/ Driving a Car	#	%	Used Condoms While Having Sexual Intercourse	#	%
Never	4	7.0	Never	11	19.3
Sometimes	17	29.8	Sometimes	31	54.5
Frequently	15	26.3	Frequently	12	21.1
Always	21	36.8	Always	3	5.3
Total	57	100.0	Total	57	100.0

(table continues)

Table 3.6 (continued)

Item 5			Item 6		
Have Shoplifted	#	%	Drove Faster than Speed Limit	#	%
Never	45	78.9	Never	6	10.5
Sometimes	10	17.5	Sometimes	19	33.3
Frequently	2	3.5	Frequently	27	47.4
Always	0	0.0	Always	5	8.8
Total	57	100.0	Total	57	100.0

Item 7			Item 8		
Used Illegal Drugs	#	%	Drank Alcohol	#	%
Never	45	78.9	Never	10	17.5
Sometimes	8	14.0	Sometimes	38	66.7
Frequently	2	3.5	Frequently	7	12.3
Always	2	3.5	Always	2	3.5
Total	57	100.0	Total	57	100.0

typical survey respondent reported she never smoked cigarettes.

As shown in Table 3.6, when 57 survey respondents were asked if they had written on public property, 46 (or 80.7 percent) had never written on public property and 11 (or 19.3 percent) had sometimes written on public property. Therefore, the typical survey respondent had never written on public property.

As shown in Table 3.6, when 57 survey respondents were asked if they wore seatbelts when driving/riding in a car, 4 (or 7 percent) never wore seatbelts when driving/riding in a car; 15 (or 26.3 percent) frequently wore seatbelts when driving/riding in a car, and 21 (or 36.8 percent) always wore seatbelts when driving/riding in a car. Therefore, the typical survey respondent always wore seatbelts when driving/riding in a car.

As shown in Table 3,6, when 57 survey respondents were asked if they used condoms while having sexual intercourse, 11 (or 19.3 percent) never used condoms while having sexual intercourse; 31 (or 54.4 percent) sometimes used condoms while having sexual intercourse; 12 (or 21.1 percent) frequently used condoms while having sexual intercourse, and three (or 5.3 percent) always

used condoms while having sexual intercourse. Therefore, the typical survey respondent sometimes used condoms while having sexual intercourse.

As shown in Table 3.6, when 57 survey respondents were asked if they have shoplifted, 45 (or 78.9 percent) have never shoplifted; 10 (or 17.5 percent) have sometimes shoplifted, and two (or 3.5 percent) have frequently shoplifted. Therefore, the typical survey respondent had never shoplifted.

As shown in Table 3.6, when 57 survey respondents were asked if they drove faster than the speed limit, six (or 10.5 percent) never drove faster than the speed limit; 19 (or 33.3 percent) sometimes drove faster than the speed limit; 27 (or 47.4 percent) frequently drove faster than the speed limit, and five (or 8.8 percent) always drove faster than the speed limit. Therefore, the typical survey respondent frequently dorve faster than the speed limit.

As shown in Table 3.6, when 57 survey respondents were asked if they used illegal drugs, 45 (or 78.9 percent) never used illegal drugs; eight (or 14 percent) sometimes used illegal drugs; two (or 3.5 percent) frequently used illegal drugs, and two (or 3.5 percent)

always used illegal drugs. Therefore, the typical survey respondent never used illegal drugs.

Lastly, as shown in Table 3.6, when 57 survey respondents were asked if they drank alcohol, 10 (or 17.5 percent) never drank alcohol; 38 (or 66.7 percent) sometimes drank alcohol; seven (or 12.3 percent) frequently drank alcohol, and two (or 3.5 percent) always drank alcohol. Therefore, the typical survey respondent sometimes drank alcohol.

It was found that the typical survey respondent never smoked cigarettes (see Item 1, Table 3.6); never wrote on public property (see Item 2, Table 3.6); always wore seatbelts when driving/riding in a car (see Item 3, Table 3.6) and sometimes used condoms while having sexual intercourse (see Item 4, Table 3.6). She never shoplifted (see Item 5, Table 3.6); frequently drove faster than the speed limit (see Item 6, Table 3.6); never used illegal drugs (see Item 7, Table 3.6); and sometimes drank alcohol (see Item 8, Table 3.6).

Consequently, for six out of eight items, survey respondents did not report being engaged in risk taking behaviors. Therefore, Hypothesis One which stated that

survey respondents would rate themselves high on risk-taking behavior was rejected.

Section C. Sexuality

Hypothesis Two stated that survey respondents would report being uncomfortable with their sexuality. The sexuality dimension was related to Hypothesis Two and contained 17 items which were items 34-50 on the PACS.

As shown in Table 3.7, when 57 survey respondents were asked to report if they planned when they were going to have sex, 9 (or 15.8 percent) never planned when they were going to have sex; 35 (or 61.4 percent) sometimes planned when they were going to have sex; nine (or 15.8 percent) frequently planned when they were going to have sex; and four (or 7 percent) always planned when they were going to have sex. Therefore, the typical survey respondent sometimes planned when she was going to have sex.

As shown in Table 3.7, when 57 survey respondents were asked if they engaged in self-masturbation, 32 (or 56.1 percent) never engaged in self-masturbation; 23 (or 40.4 percent) sometimes engaged in self-masturbation; and two (or 3.5 percent) frequently engaged in self-

Table 3.7

Frequency Analysis: Comfortability with Sexuality in Numbers (#) and Percentages (%) (N=57)

Item 1			Item 2		
Planned to Have Sex	#	%	Engaged in Self-Masturbation	#	%
Never	9	15.8	Never	32	56.1
Sometimes	35	61.4	Sometimes	23	40.4
Frequently	9	15.8	Frequently	2	3.5
Always	4	7.0	Always	0	0.0
Total	57	100.0	Total	57	100.0

Item 3			Item 4		
Felt Homosexuality was Acceptable Lifestyle	#	%	Birth Control-Responsibility of Both Partners	#	%
Strongly Disagree	21	36.8	Strongly Disagree	3	5.3
Disagree	19	33.3	Disagree	1	1.8
Agree	15	26.3	Agree	28	49.1
Strongly Agree	2	3.5	Strongly Agree	25	43.9
Total	57	100.0	Total	57	100.0

(table continues)

Table 3.7 (continued)

Item 5			Item 6		
Birth Control-Responsibility of Female	#	%	Birth Control-Responsibility of Male	#	%
Strongly Disagree	12	21.1	Strongly Disagree	12	21.1
Disagree	14	24.6	Disagree	17	29.8
Agree	24	42.1	Agree	24	42.1
Strongly Agree	7	12.3	Strongly Agree	4	7.0
Total	57	100.0	Total	47	100.0

Item 7			Item 8		
Practiced Variety of Sexual Positions	#	%	Feared Getting Pregnant	#	%
Strongly Disagree	0	0.0	Never	6	10.5
Disagree	7	12.3	Sometimes	33	57.9
Agree	43	75.4	Frequently	8	14.0
Strongly Agree	7	12.3	Always	10	17.5
Total	57	100.0	Total	57	100.0

(table continues)

Table 3.7 (continued)

Item 9			Item 10		
Felt Sex More Important Than Romance	#	%	Felt Guilty About Sex	#	%
Strongly Disagree	21	36.8	Never	34	59.6
Disagree	31	54.4	Sometimes	22	38.6
Agree	4	7.0	Frequently	1	1.8
Strongly Agree	1	1.8	Always	0	0.0
Total	57	100.0	Total	57	100.0

Item 11			Item 12		
Embarrassed to Buy Birth Control	#	%	Felt It Is Okay to Have Sex	#	%
Never	44	77.2	Never	0	0.0
Sometimes	9	15.8	Sometimes	14	24.6
Frequently	4	7.0	Frequently	17	29.8
Always	0	0.0	Always	26	45.6
Total	57	100.0	Total	57	100.0

(table continues)

Table 3.7 (continued)

Item 13 Could Not Discuss Birth Control With Partner-Uncomfortable	#	%	Item 14 Embarrassed to Use Birth Control-Implies Promiscuity	#	%
Strongly Disagree	32	56.1	Strongly Disagree	37	64.9
Disagree	18	31.6	Disagree	18	31.6
Agree	6	10.5	Agree	1	1.8
Strongly Agree	1	1.8	Strongly Agree	1	1.8
Total	57	100.0	Total	57	100.0

Item 15 Would Feel Insulted If Partner Brought up Birth Control	#	%	Item 16 Felt Male Should Be Dominant Sex Partner	#	%
Strongly Disagree	38	66.7	Strongly Disagree	12	21.1
Disagree	15	26.3	Disagree	35	61.4
Agree	2	3.5	Agree	8	14.0
Strongly Agree	2	3.5	Strongly Agree	2	3.5
Total	57	100.0	Total	57	100.0

(table continues)

Table 3.7 (continued)

Item 17 Expected to Achieve Orgasm When Having Sex	#	%
Never	3	5.3
Sometimes	21	36.8
Frequently	25	43.9
Always	8	14.0
Total	57	100.0

masturbation. Therefore, the typical survey respondent never engaged in self-masturbation.

As shown in Table 3.7, when 57 survey respondents were asked if they believed homosexuality was an acceptable lifestyle, 21 (or 36.8 percent) strongly disagreed that homosexuality was an acceptable lifestyle; 19 (or 33.3 percent) disagreed that homosexuality was an acceptable lifestyle; 15 (or 26.3 percent) agreed that homosexuality was an acceptable lifestyle; and two (or

3.5 percent) strongly agreed that homosexuality was an acceptable lifestyle. Therefore, the typical survey respondent strongly disagreed that homosexuality was an acceptable lifestyle.

As shown in Table 3.7, when 57 survey respondents were asked if birth control was the responsibility of both partners, three (or 5.3 percent) strongly disagreed that birth control was the responsibility of both partners; one (or 1.8 percent) disagreed that birth control was the responsibility of both partners; 28 (or 49.1 percent) agreed that birth control was the responsibility of both partners; and 25 (or 43.9 percent) strongly agreed that birth was the responsibility of both partners. Therefore, the typical survey respondent agreed that birth control was the responsibility of both partners.

As shown in Table 3.7, when 57 survey respondents were asked if birth control was the responsibility of the female, 12 (or 21.1 percent) strongly disagreed that birth control was the responsibility of the female; 14 (or 24.6 percent) disagreed that birth control was the responsibility of the female; 24 (or 42.1 percent) agreed that birth control was the responsibility of the female;

and seven (or 12.3 percent) strongly agreed that birth control was the responsibility of the female. Therefore, the typical survey respondent agreed that birth control was the responsibility of the female.

As shown in Table 3.7, when 57 survey respondents were asked if birth control was the responsibility of the male, 12 (or 21.1 percent) strongly disagreed that birth control was the responsibility of the male; 17 (or 29.8 percent) disagreed that birth control was the responsibility of the male; 24 (or 42.1 percent) agreed that birth control was the responsibility of the male; and four (or 7 percent) strongly agreed that birth control was the responsibility of the male. Therefore, the typical survey respondent agreed that birth control was the responsibility of the male.

As shown in Table 3.7, when 57 survey respondents were asked if they practiced a variety of sexual positions, seven (or 12.3 percent) disagreed that they practiced a variety of sexual positions; 43 (or 75.4 percent) agreed that they practiced a variety of sexual positions and seven (or 12.3 percent) strongly agreed that they practiced a variety of sexual positions.

Therefore, the typical survey respondent agreed that she practiced a variety of sexual positions.

As shown in Table 3.7, when 57 survey respondents were asked if they feared getting pregnant, six (or 10.5 percent) never feared getting pregnant; 33 (or 57.9 percent) sometimes feared getting pregnant; eight (or 14 percent) frequently feared getting pregnant; and 10 (or 17.5 percent) always feared getting pregnant. Therefore, the typical survey respondent sometimes feared getting pregnant.

As shown in Table 3.7, when 57 survey respondents were asked if having sex was more important than romance, 21 (or 36.8 percent) strongly disagreed that having sex was more important than romance; 31 (or 54.4 percent) disagreed that having sex was more important than romance; four (or 7 percent) agreed that having sex was more important than romance; and one (or 1.8 percent) strongly agreed that having sex was more important than romance. Therefore, the typical survey respondent disagreed that having sex was more important than romance.

As shown in Table 3.7, when 57 survey respondents were asked if they felt guilty about having sex, 34 (or

59.6 percent) never felt guilty about having sex; 22 (or 38.6 percent) sometimes felt guilty about having sex; and one (or 1.8 percent) frequently felt guilty about having sex. Therefore, the typical survey respondent never felt guilty about having sex.

As shown in Table 3.7, when 57 survey respondents were asked if they were embarrassed to go into a drug store to buy birth control, 44 (or 77.2 percent) were never embarrassed to go into a drug store to buy birth control; nine (or 15.8 percent) were sometimes embarrassed to go into a drug store to buy birth control; and four (or 7 percent) were frequently embarrassed to go into a drug store to buy birth control. Therefore, the typical survey respondent was never embarrassed to go into a drug store to buy birth control.

As shown in Table 3.7, when 57 survey respondents were asked if they felt it was okay to have sex, 14 (or 24.6 percent) sometimes felt it was okay to have sex; 17 (or 29.8 percent) frequently felt it was okay to have sex; and 26 (or 45.6 percent) always felt it was okay to have sex. Therefore, the typical survey respondent always felt it was okay to have sex.

As shown in Table 3.7, when 57 survey respondents were asked if they would feel uncomfortable discussing birth control with their partner, 32 (or 56.1 percent) strongly disagreed that they would feel uncomfortable discussing birth control with their partner; 18 (or 31.6 percent) disagreed that they would feel uncomfortable discussing birth control with their partner; six (or 10.5 percent) agreed that they would feel uncomfortable discussing birth control with their partner; and one (or 1.8 percent) strongly agreed that she would feel uncomfortable discussing birth control with her partner. Therefore, the typical survey respondent strongly disagreed that she would feel uncomfortable discussing birth control with her partner.

As shown in Table 3.7, when 57 survey respondents were asked if they felt embarrassed about using birth control because it implies sexual promiscuity, 37 (or 64.9 percent) strongly disagreed that they felt embarrassed about using birth control because it implies sexual promiscuity; 18 (or 31.6 percent) disagreed that they felt embarrassed about using birth control because it implies sexual promiscuity; one (or 1.8 percent) strongly agreed that she felt embarrassed to use birth

control because it implies sexual promiscuity. Therefore, the typical survey respondent strongly disagreed that she felt embarrassed to use birth control because it implies sexual promiscuity.

As shown in Table 3.7, when 57 survey respondents were asked if they would feel insulted if their sexual partner brought up the subject of using birth control, 38 (or 66.7 percent) strongly disagreed that they would feel insulted if their sexual partner brought up the subject of using birth control; 15 (or 26.3 percent) disagreed that they would feel insulted if their sexual partner brought up the subject of using birth control; two (or 3.5 percent) agreed that they would feel insulted if their sexual partner brought up the subject of using birth control; and two (or 3.5 percent) strongly agreed that they would feel insulted if their sexual partner brought up the subject of using birth control. Therefore, the typical survey respondent strongly disagreed that she would feel insulted if her sexual partner brought up the subject of using birth control.

As shown in Table 3.7, when 57 survey respondents were asked if the male should be the dominant sexual partner, 12 (or 21.1 percent) strongly disagreed that the

male should be the dominant sexual partner; 35 (or 61.4 percent) disagreed that the male should be the dominant sexual partner; eight (or 14 percent) agreed that he male should be the dominant sexual partner; and two (or 3.5 percent) strongly agreed that the male should be the dominant sexual partner. Therefore, the typical survey respondent disagreed that the male should be the dominant sexual partner.

As shown in Table 3.7, when 57 survey respondents were asked if they expected to achieve orgasm when they had sex, three (or 5.3 percent) never expected to achieve orgasm when they had sex; 21 (or 36.8 percent) sometimes expected to achieve orgasm when they had sex; and 25 (or 43.9 percent) frequently expected to achieve orgasm when they had sex; and eight (or 14 percent) reported they always expected to achieve orgasm when they had sex. Therefore, the typical survey respondent reported she frequently expected to achieve orgasm when she had sex.

It was found that the typical survey respondent sometimes planned to have sex (see Item 1, Table 3.7); never engaged in self-masturbation (see Item 2, Table 3.7); strongly disagreed that homosexuality was an acceptable lifestyle (see Item 3, Table 3.7); agreed that

birth control was the responsibility of both partners (see Item 4, Table 3.7); and agreed that birth control was the responsibility of the female (see Item 5, Table 3.7).

The typical survey respondent agreed that birth control was the responsibility of the male (see Item 6, Table 3.7); agreed that she practiced a variety of sexual positions (see Item 7, Table 3.7); sometimes feared getting pregnant (see Item 8, Table 3.7); disagreed that having sex was more important than romance (see Item 9, Table 3.7); and never felt guilty about having sex (see Item 10, Table 3.7).

The typical survey respondent was never embarrassed to buy birth control (see Item 11, Table 3.7); always felt it was okay to have sex (see Item 12, Table 3.7); could discuss birth control with her partner without feeling uncomfortable (see Item 13, Table 3.7); strongly disagreed that she felt embarrassed to use birth control methods (see Item 14, Table 3.7). She strongly disagreed that she would feel insulted if her partner brought up birth control (see Item 15, Table 3.7); disagreed that the male should be the dominant sexual partner (see Item

16, Table 3.7); and frequently expected to achieve orgasm (see Item 17, Table 3.7).

Consequently, for 13 out of 17 items, survey respondents did not report being uncomfortable with their sexuality. Therefore, Hypothesis Two which stated that survey respondents would report being uncomfortable with their sexualiy was rejected.

Section D. Quality of Sexual Relationship

Hypothesis Three stated that survey respondents would report being uncomfortable with the quality of their present sexual relationship. The quality of sexual relationship dimension was related to Hypothesis Three and contained 11 items which were Items 51-61 on the PACS.

As shown in Table 3.8, when 57 survey respondents were asked if they had a permanent relationship, four (or 7 percent) strongly disagreed that they had a permanent relationship; 12 (or 21.1 percent) disagreed that they had a permanent relationship; 17 (or 29.8 percent) agreed that they had a permanent relationship; and 24 (or 42.1 percent) strongly agreed that they had a permanent

Table 3.8

Frequency Analysis: Quality of Sexual Relationship in Numbers (#) and Percentages (%) (N=57)

Item 1			Item 2		
Had a Permanent Relationship	#	%	Felt Couples Should Make Love Nearly Every Day	#	%
Strongly Disagree	4	7.0	Strongly Disagree	6	10.5
Disagree	12	21.1	Disagree	33	57.9
Agree	17	29.8	Agree	14	24.6
Strongly Agree	24	42.1	Strongly Agree	4	7.0
Total	57	100.0	Total	57	100.0

Item 3			Item 4		
Had Close Relationship With Partner	#	%	Felt Communication Essential for Sexual Relationship	#	%
Strongly Disagree	5	8.8	Strongly Disagree	0	0.0
Disagree	11	19.3	Disagree	3	5.3
Agree	18	31.6	Agree	20	35.1
Strongly Agree	23	40.4	Strongly Agree	34	59.6
Total	57	100.0	Total	57	100.0

(table continues)

Table 3.8 (continued)

Item 5 Felt Communication Essential for Emotional Relationship	#	%	Item 6 Did Not Like Explaining to Partner Why Made Decision	#	%
Strongly Disagree	8	14.0	Strongly Disagree	1	1.8
Disagree	20	35.1	Disagree	10	17.5
Agree	23	40.4	Agree	43	75.4
Strongly Agree	6	10.5	Strongly Agree	3	5.3
Total	57	100.0	Total	57	100.0

Item 7 Felt Living Together Good Idea	#	%	Item 8 Shared in Expense of Dating with Partner	#	%
Strongly Disagree	8	14.0	Strongly Disagree	1	1.8
Disagree	20	35.1	Disagree	10	17.5
Agree	23	40.4	Agree	43	75.4
Strongly Agree	6	10.5	Strongly Agree	3	5.3
Total	57	100.0	Total	57	100.0

(table continues)

Table 3.8 (continued)

Item 9			Item 10		
Partner's Feelings Important in Decision Concerning Pregnancy	#	%	Felt Partner Was Trustworthy	#	%
Strongly Disagree	7	12.3	Strongly Disagree	1	1.8
Disagree	7	12.3	Disagree	6	10.5
Agree	26	45.6	Agree	32	56.1
Strongly Agree	17	29.8	Strongly Agree	18	31.6
Total	57	100.0	Total	57	100.0

Item 11		
Thought Romance more Important Than Sex	#	%
Strongly Disagree	2	3.5
Disagree	7	12.3
Agree	32	56.1
Strongly Agree	16	28.1
Total	57	100.0

relationship. Therefore, the typical survey respondent strongly agreed that she had a permanent relationship.

As shown in Table 3.8, when 57 survey respondents were asked if they felt couples should make love nearly every day, six (or 10.5 percent) strongly disagreed that couples should make love nearly every day; 33 (or 57.9 percent) disagreed that couples should make love nearly every day; 14 (or 24.6 percent) agreed that couples should make love nearly every day; and four (or 7 percent) strongly agreed that couples should make love nearly every day. Therefore, the typical survey respondent disagreed that couples should make love nearly every day.

As shown in Table 3.8, when 57 survey respondents were asked if they had a close relationship with their partner, five (or 8.8 percent) strongly disagreed that they had a close relationship with their partner; 11 (or 19.3 percent) disagreed that they had a close relationship with their partner; 18 (or 31 percent) agreed that they had a close relationship with their partner; and 23 (or 40.4 percent) strongly agreed that they had a close relationship with their partner.

Therefore, the typical survey respondent strongly agreed that she had a close relationship with her partner.

As shown in Table 3.8, when 57 survey respondents were asked if they felt communication was essential for the quality of their sexual relationship, three (or 5.3 percent) disagreed that they felt communication was essential for the quality of their sexual relationship; 20 (or 35.1 percent) agreed that they felt communication was essential for the quality of their sexual relationship; and 34 (or 59.6 percent) strongly agreed that they felt communication was essential for the quality of their sexual relationship. Therefore, the typical survey respondent strongly agreed that she felt communication was essential for the quality of her sexual relationship.

As shown in Table 3.8, when 57 survey respondents were asked if they felt communication was essential for the quality of their emotional relationship, 22 respondents (or 38.6 percent) agreed that they felt communication was essential for the quality of their emotional relationship and 35 (or 61.4 percent) strongly agreed that they felt communication was essential for the quality of their emotional relationship. Therefore, the

typical survey respondent strongly agreed that she felt communication was essential for the quality of her emotional relationship.

As shown in Table 3.8, when 57 survey respondents were asked if they did not like explaining to their partners why they made a decision, 12 (or 21.1 percent) strongly disagreed that they did not like explaining to their partners why they made a decision; 31 (or 54.4 percent) disagreed that they did not like explaining to their partners why they made a decision; 12 (or 21.1 percent) agreed that they didn't like explaining to their partners why they made a decision; and two (or 3.5 percent) strongly agreed that they did not like explaining to their partners why they made a decision. Therefore, the typical survey respondent disagreed that she didn't like explaining to her partner why she made a decision.

As shown in Table 3.8, when 57 survey respondents were asked if living together before marriage was a good idea, eight (or 14 percent) strongly disagreed with the idea of living together before marriage; 20 (or 35.1 percent) disagreed with the idea of living together before marriage; 23 (or 40.4 percent) agreed with the

idea of living together before marriage; and six (or 10.5 percent) strongly agreed with the idea of living together before marriage. Therefore, the typical survey respondent agreed with the idea of living together before marriage.

As shown in Table 3.8, when 57 survey respondents were asked if they shared in the expense of dating with their partners, one (1.8 percent) strongly disagreed that she shared in the expense of dating with her partner; 10 (or 17.5 percent) disagreed that they shared in the expense of dating with their partner; 43 (or 75.4 percent) agreed that they shared in the expense of dating with their partner; and three (or 5.3 percent) strongly agreed that they shared in the expense of dating with their partner. Therefore, the typical survey respondent agreed that she shared in the expense of dating with her partner.

As shown in Table 3.8, when 57 survey respondents were asked if their partner's feeling were important in the decision-making process concerning their pregnancy, seven (or 12.3 percent) strongly disagreed that their partner's feelings were important in the decision-making process concerning their pregnancy; seven (or 12.3

percent) disagreed that their partner's feelings were important in the decision-making process concerning their pregnancy; 26 (or 45.6 percent) agreed that their partner's feelings were important in the decision-making process concerning their pregnancy; and 17 (or 29.8 percent) strongly agreed that their partner's feelings were important in the decision-making process concerning their pregnancy. Therefore, the typical survey respondent agreed that her partner's feelings were important in the decision-making process concerning her pregnancy.

As shown in Table 3.8, when 57 survey respondents were asked if their partners were trustworthy, one (or 1.8 percent) strongly disagreed that her partner was trustworthy; six (or 10.5 percent) disagreed that their partners were trustworthy; 32 (or 56.1 percent) agreed that their partners were trustworthy; and 18 (or 31.6 percent) strongly agreed that their partners were trustworthy. Therefore, the typical survey respondent agreed that her partner was trustworthy.

As shown in Table 3.8, when 57 survey respondents were asked if they thought romance was more important than having sex, two (or 3.5 percent) strongly disagreed

that they thought romance was more important than having sex; seven (or 12.3 percent) disagreed that they thought romance was more important than having sex; 32 (or 56.1) agreed that they thought romance was more important than having sex; and 16 (or 28.1 percent) strongly agreed that they thought romance was more important than having sex. Therefore, the typical survey respondent agreed that she thought romance was more important than having sex.

It was found that the typical survey respondent strongly agreed that she had a permanent relationship (see Item 1, Table 3.8); disagreed that couples should make love nearly every day (see Item 2, Table 3.8); strongly disagreed that she had a close relationship with her partner (see Item 3, Table 3.8); strongly agreed that communication was essential for the sexual relationship (see Item 4, Table 3.8) and strongly agreed that communication was essential for the emotional relationship (see Item 5, Table 3.8)

The typical survey respondent disagreed that she didn't like explaining decisions to her partner (see Item 6, Table 3.8); agreed with living together before marriage (see Item 7, Table 3.8); agreed she shared in the expense of dating (see Item 8, Table 3.8); agreed her

partner was important in the decision-making process concerning her pregnancy (see Item 9, Table 3.8); agreed her partner was trustworthy (see Item 10, Table 3.8); and agreed that romance was more important than having sex (see Item 11, Table 3.8).

Consequently, for nine out of 11 items, survey respondents did not report being uncomfortable with the quality of their present sexual relationship. Therefore, Hypothesis Three which stated that survey respondents would report being uncomfortable with the quality of their sexual relationship was rejected.

Section E. Attitudes Toward Children

Hypothesis Four stated that survey respondents would report having a poor attitude toward children. The attitude toward children dimension was related to Hypothesis Four and contained 10 items which were items 62-71 on the PACS.

As shown in Table 3.9, when 57 survey respondents were asked if they had a desire to have a/another child, seven (or 12.3 percent) strongly disagreed that they had a desire to have a/another child; five (or 8.8 percent) disagreed that they had a desire to have a/another child;

Table 3.9

Frequency Analysis: Attitudes Toward Children in Numbers (#) and Percentages (%) (N=57)

Item 1			Item 2		
Had Desire to Have to Have A/Another Child	#	%	Felt Woman Not Complete Without Children	#	%
Strongly Disagree	7	12.3	Strongly Disagree	16	28.1
Disagree	5	8.8	Disagree	33	57.9
Agree	21	36.8	Agree	7	12.3
Strongly Agree	24	42.1	Strongly Agree	1	1.8
Total	57	100.0	Total	57	100.0

Item 3			Item 4		
Felt a Child/Children Make Family Complete	#	%	Believed Child Should be Raised by Both Parents	#	%
Strongly Disagree	7	12.3	Strongly Disagree	0	0.0
Disagree	27	47.4	Disagree	7	12.3
Agree	22	38.6	Agree	30	52.6
Strongly Agree	1	1.8	Strongly Agree	20	35.1
Total	57	100.0	Total	57	100.0

(table continues)

Table 3.9 (continued)

Item 5			Item 6		
Would Never Date/ Marry Someone with Children	#	%	Felt Child Should be Wanted	#	%
Strongly Disagree	13	22.8	Strongly Disagree	0	0.0
Disagree	35	61.4	Disagree	0	0.0
Agree	7	12.3	Agree	17	29.8
Strongly Agree	2	3.5	Strongly Agree	40	70.2
Total	57	100.0	Total	57	100.0

Item 7			Item 8		
Felt Having Child At Wrong Time Was Mistake	#	%	Children Were Treasures of Life	#	%
Strongly Disagree	0	0.0	Strongly Disagree	0	0.0
Disagree	6	10.5	Disagree	8	14.0
Agree	25	43.9	Agree	29	50.9
Strongly Agree	26	45.6	Strongly Agree	20	35.1
Total	57	100.0	Total	57	100.0

(table continues)

Table 3.9 (continued)

Item 9			Item 10		
Did Not Have Emotional Resources to Have Child	#	%	Did Not Have Financial Resources to Have Child	#	%
Strongly Disagree	1	1.8	Strongly Disagree	2	3.5
Disagree	12	21.1	Disagree	8	14.0
Agree	24	42.1	Agree	20	35.1
Strongly Agree	20	35.1	Strongly Agree	27	47.4
Total	57	100.0	Total	57	100.0

21 (or 36.8 percent) agreed that they had a desire to have a/another child; and 24 (or 42.1 percent) strongly agreed that they had a desire to have a/another child. Therefore, the typical survey respondent strongly agreed that she had a desire to have a/another child.

As shown in Table 3.9, when 57 survey respondents were asked if a woman was not complete without children, 16 (28.1 percent) strongly disagreed that a woman was not complete without children; 33 (or 57.9 percent) disagreed that a woman was not complete without children; seven (or

12.3 percent) agreed that a woman was not complete without children; and one (or 1.8 percent) strongly agreed that a woman was not complete without children. Therefore, the typical survey respondent disagreed that a woman was not complete without children.

As shown in Table 3.9, when 57 survey respondents were asked if a child/children made a family complete, seven(or 12.3 percent) strongly disagreed that a child/children made a family complete; 27 (or 47.4 percent) disagreed that a child/children made a family complete; 22 (or 38.6 percent) agreed that a child/children made a family complete; and one (or 1.8 percent) strongly agreed that a child/children made a family complete. Therefore, the typical survey respondent disagreed that a child/children made a family complete.

As shown in Table 3.9, when 57 survey respondents were asked if they believed a child should be raised by both parents, seven (or 12.3 percent) disagreed that they believed a child should be raised by both parents; 30 (or 52.6 percent) agreed that they believed a child should be raised by both parents; and 20 (or 35.1 percent) srongly agreed that they believed a child should be

raised by both parents. Therefore, the typical survey respondent agreed that she believed a child should be raised by both parents.

As shown in Table 3.9, when 57 survey respondents were asked if they would never date/marry someone who already had children, 13 (22.8 percent) strongly disagreed that they would never date/marry someone who already had children; 35 (or 61.4 percent) disagreed that they would never date/marry someone who already had children; seven (or 12.3 percent) agreed that they would never date/marry someone who already had children; and two (or 3.5 percent) strongly agreed that they would never date/marry someone who already had children. Therefore, the typical survey respondent disagreed that she never would date/marry someone who already had children.

As shown in Table 3.9, when 57 survey respondents were asked if they felt a child should be wanted, 17 (or 29.8 percent) agreed that they felt a child should be wanted and 40 (or 70.2 percent) strongly agreed that they felt a child should be wanted. Therefore, the typical survey respondent strongly agreed that she felt a child should be wanted.

As shown in Table 3.9, when 57 survey respondents were asked if having a child when they felt was the wrong time was a mistake, five (or 8.8 percent) disagreed that having a child when they felt it was the wrong time was a mistake; 25 (or 43.9 percent) agreed that having a child when they felt it was the wrong time was a mistake; and 26 (or 45.6 percent) strongly agreed that having a child when they felt it was the wrong time was a mistake. Therefore, the typical survey respondent strongly agreed that having a child when she felt it was the wrong time was a mistake.

As shown in Table 3.9, when 57 survey respondents were asked if children were the treasures of life, eight (or 14 percent) disagreed that children were the treasures of life; 29 (or 50.9 percent) agreed that children were the treasures of life; and 20 (or 35.1 percent) strongly agreed that children were the treasures of life. Therefore, the typical survey respondent agreed that children were the treasures of life.

As shown in Table 3.9, when 57 survey respondents were asked if they did not think they had the emotional resources to have a child, one (or 1.8 percent) strongly disagreed that she did not have the emotional resources

to have a child; 12 (or 21.1 percent) disagreed that they did not have the emotional resources to have a child; 24 (or 42.1 percent) agreed that they did not have the emotional resources to have a child; and 20 (or 35.1 percent) strongly agreed that they did not have the emotional resources to have a child. Therefore, the typical survey respondent agreed that she did not have the emotional resources to have a child.

As shown in Table 3.9, when 57 survey respondents were asked if they did not have the financial resources to have a child, two (3.5 percent) strongly disagreed that they did not have the financial resources to have a child; eight (or 14 percent) disagreed that they did not have the financial resources to have a child; 20 (or 35.1 percent) agreed that they did not have the financial resources to have a child; and 27 (or 47.4 percent) strongly agreed that they did not have the financial resources to have a child. Therefore, the typical survey respondent strongly agreed that she did not have the financial resources to have a child.

It was found that the typical survey respondent strongly agreed she desired a/another child (see Item 1, Table 3.9); disagreed that a woman was not complete

without children (see Item 2, Table 3.9); disagreed that children made a family complete (see Item 3, Table 3.9); agreed that a child should be raised by both parents (see Item 4, Table 3.9); and disagreed that she would not marry/date a man with children (see Item 5, Table 3.9).

The typical survey respondent strongly agreed a child should be wanted (see Item 6, Table 3.9); strongly agreed it was a mistake to have a child at the wrong time (see Item 7, Table 3.9); agreed that children were the treasures of life (see Item 8, Table 3.9); agreed she did not have the emotional resources to have a child (see Item 9, Table 3.9); and strongly agreed she did not have the financial resources to have a child (see Item 10, Table 3.9).

Consequently, for six out of 10 items, survey respondents did not report having a poor attitude toward children. Therefore, Hypothesis Four which stated that survey respondents would report a poor attitude toward children was rejected.

Summary: Results for Study Hypotheses

There were four hypotheses that were postulated.

Of these, none were supported by the data. Consequently, they were rejected.

CHAPTER IV

Discussion

The primary purpose of this study was to obtain information regarding the characteristics of women having repeat abortions. Additionally, this study described the risk-taking behavior, sexuality, quality of sexual relationships, and attitudes toward children of a selected group of women who had repeat abortions.

There were four hypotheses generated from the above-mentioned four factors. Results regarding each hypothesis are discussed below. Recommendations, limitations, and implications conclude this study.

The characteristics of women having repeat abortions in this study were as follows: the typical survey respondent was Black and between 21-25 years of age. She was single, never married, had no children, and had obtained some college education. She was employed full-time and had an annual income of $20,000-$24,999.

The typical survey respondent listed Baptist as her religious preference and reported she attended a place of worship sometimes. She listed her political preference as a pro-choice Democrat.

The typical survey respondent had one previous abortion, did not presently live with her sexual partner, and engaged in sexual intercourse one to three times a week on the average. She learned the facts of life from her mother/parent and friends.

The typical survey respondent planned to use birth control pills and condoms in the future as her choice of contraceptive methods. Finally, she did not plan to use the IUD, diaphragm, cervical cap, birth control gel, birth control foam, contraceptive sponge, or spermidical suppositories as contraceptive methods.

Risk-Taking Behavior

Risk-taking behavior was defined as behaviors which may cause hazard, peril, or jeopardy to a person. It had been offered that survey respondents would rate themselves high on risk-taking behavior (i.e., Hypothesis One).

However, study data did not support that assumption and the hypothesis was rejected. This study's findings were similar to prior research (Crosbie & Bitte, 1982) which did not support a theory of contraceptive risk-taking behavior (Luker, 1975). For example, Luker (1975)

had argued that for female contraceptive risk-taking, each successful risk substantiated the idea that the woman could get away with risk-taking indefinitely if she did not get pregnant after taking risks.

Consequently, there appears to be no evidence available to support or refute these findings which indicated that repeat abortion patients are not engaged in risk-taking behaviors. Therefore, it is not known if the types of risk-taking behaviors in this study are related to the decision to have an abortion. Yet, women still take contraceptive risks and very few women always use contraceptives. However, prior to the current research study, it seems there was no research which focused on a variety of risk-taking behaviors.

It is interesting to note that most of the survey respondents listed prochoice as a political preference. Prochoice advocates are usually associated with speaking out on behalf of women having "freedom of choice" in the decision-making process of abortion as an option to unwanted pregnancy.

Therefore, the survey respondents seem to have been willing to take risks on a highly controversial issue and classify themselves as prochoice. It is interesting that

these respondents seemingly did not engage in behaviors that have generally been considered risk-taking behaviors in society such as smoking cigarettes or using illegal drugs.

Survey respondents may have been risk takers in some particular areas, but not in others. In other words, it may be difficult to determine the overall level of risk-taking with regard to select given behaviors based on the responses of subjects in this study.

Sexuality

Sexuality was defined as the quality or state of being sexual, the condition of having sex, or expressing of sexual receptivity or interest (McKinney & Sprecher, 1989). It was stated that survey respondents would report being uncomfortable with their sexuality in the second study hypothesis. However, this hypothesis was also rejected.

Previous research by Woodhouse (1982) supported this study hypothesis. For instance, it was found that the study subjects reported being embarrassed to discuss the issue of contraception with their sexual partner, had a fear of being viewed as promiscuous and did not regard

sex as fun or for pleasure. There may be times when women simply cannot, will not, or would not announce, to herself or anyone else, that they are people with physical desires and longings. As a result, women may split off their action, which is sexual intercourse, from its acknowledgement, which may be contraception.

However, in this study survey respondents did not report being uncomfortable with their sexuality as hypothesized. For example, survey respondents reported they felt it was alright to have sex and to achieve orgasm when having sex.

Cassell (1984) described a society that is constantly changing with regard to female sexuality. The findings of this study are interesting in that they tend to dispel the notion that women are not sexually free. Women have been willing to risk unwanted pregnancy for reasons such as romance, spontaneity, and the need to be seduced to enjoy sexual intercourse.

However, based on the results of this study, it would appear that women do not have the traditional hangups that have been depicted in the literature. Contrary to traditional or past belief, these survey

respondents seem to be comfortable in expressing their sexuality.

Quality of Sexual Relationships

Sexual relationships are defined as a relationship between people that involve the expression of sexuality (McKinney & Sprecher, 1989). A third study hypothesis stated that survey respondents would report being uncomfortable with the quality of their present sexual relationship. Yet, this hypothesis was not supported by the study data. Consequently, it was rejected.

Brewer (1977) found that women who indicated unsettled relations with their sexual partners were more prone to erratic contraceptive use. As a result, it was offered that such behavior would often lead to unwanted pregnancy, which in turn placed the woman in the decision-making dilemma regarding options for unwanted pregnancy. The options for unwanted pregnancy are to have the baby, give the baby up for adoption, or have an abortion.

Contrarily, study findings did not support the notion that women having repeat abortions were uncomfortable with the quality of their present sexual

relationship. Most survey respondents reported they had both a permanent and close relationship with their sexual partner.

It is interesting to note that most survey respondents in this study did not live with their sexual partners and were single. However, since these survey respondents reported having close, permanent relationships a question might be posed as to why they are choosing the option of abortion to an unwanted pregnancy which would serve to remove the product of conception from their close relationships. This contradicts research by Niemela et al. (1981) which indicated that women having repeat abortions had a history of broken legalized or non-legalized partner relationships more often.

The findings of this study were interesting since the typical survey respondent was single and never married. Therefore, there were no legal ties that would warrant the maintenance of a permanent or close relationship with a sexual partner. It appears that the quality of the sexual relationship of the survey

respondents had not been significantly impacted on by their marital status.

Attitudes Toward Children

The final hypothesis stated that survey respondents would report having a poor attitude toward children. Again, this hypothesis was not given support and was rejected.

Fine (1985) has suggested that society programs women to desire motherhood. It has been said that women experience socio-cultural pressures which make motherhood appear to be a natural aspect of feminity.

On the other hand, Bozarth (1987) presented an aspect of maternal cruelty which leads to major concerns such as child abuse and neglect. This was recognized as maternal hostility toward children which included forms of child abuse such as infanticide, beating, and neglect. There appears to have been no prior research which supported or refuted the assumption that women having repeat abortions have a poor attitude toward children.

According to study data, survey respondents did not report having poor attitudes toward children. For example, most survey respondents reported that they

desired a/another child, they would marry/date a man with children, and agreed that children are the treasures of life. In light of these findings, it is interesting that survey respondents chose abortion as the option to their unwanted pregnancies.

Conclusions

Unwanted pregnancy may be a result of failures inherent in the contraceptive methods themselves. But, a large amount of cases of unwanted pregnancy are a result of human error with improper or inconsistent use of contraceptive methods.

Some women do not use contraceptive methods regularly, even when they are involved in an ongoing sexual relationship. A large number of unwanted pregnancies are a result of failure to use any contraception at all.

Today, clinics offer a full range of preventive contraceptive methods, drugstores have enormous sections of over-the-counter contraceptive methods, and information on contraception is available. It would seem that women would be more educated since they are

constantly surrounded with talk of birth control and birth control supplies are readily available.

At times, contraception carries the same taboos as sexual intercourse and similar to the issue of sexual intercourse, can become an emotionally charged dumping ground for women's negative or ambivalent feelings about their sexuality. Contraception can be viewed as the cold hard announcement of planned sex. Women are still traditional in that they cannot or do not deal with the idea of planned sex. This issue is of special significance in this study because the typical survey respondent was single and this issue may not apply to married women.

In summary, women still take contraceptive risks and very few women always use contraception. It would appear that at times women risk unwanted pregnancy, not because they do not always know about birth control and not because they do not know where to get birth control. Women may risk unwanted pregnancy because they are ambivalent about their sexuality which leads them to deny that they might need contraceptive methods.

Recommendations for Future Research

The issue of abortion is a highly controversial topic in this society today. There has been an increased focus on contraceptive technology and education. Although most of the survey respondents indicated they had obtained some college education, it appears this education did not include contraceptive methods. There are still many myths and false beliefs concerning contraception in spite of age or educational level. It cannot be assumed that if a person is educated or has a middle class income that she will place more value on the use of contraceptives as having priority in her life. Finally, it cannot be assumed that she will have sexually liberated opinions about planned sex. As Cassell (1984) indicated in describing the "swept away theory," women deny responsibility for their sexuality and wrap their desire in a cloak of romance and need "love" in order to have sex. The swept away strategy continues to be a coping mechanism which allows women to be sexual in a society that is still ambivalent about and at times, condemnatory of female sexuality.

Consequently, the following recommendations are made for future research which focuses on abortion patients:

1. Research should examine the many factors which may contribute to women seeking an abortion.
2. Counselors often play an important role in abortion counseling. The counselors may add to the base of knowledge concerning characteristics of women having abortion by giving their summary of any significant information presented during the counseling session.
3. Researchers may be able to portray a more accurate description of characteristics of the abortion patient by gathering information from other sources such as medical records and information given by significant others in regards to the patient.
4. Researchers should obtain samples from public and private facilities in order to have subjects from all levels of socioeconomic statuses.
5. Researchers should examine subjects from all areas of the United States to ensure a more varied population in terms of geographic locations. There are different attitudes and values that are associated with the various

areas of the United States. Researchers should find out where subjects were born or raised.

Implications for Counselors

The following recommendations are made for counselors in regard to the issue of unwanted pregnancy:

1. Counselors should seek to promote increased education regarding contraceptive methods by offering additional contraceptive counseling in gynecological and abortion facilities.
2. Counselors should seek to provide additional contraceptive education to middle and high school level students by speaking to classes and individual students in the school setting. Therefore, students will receive further education regarding their sexuality. Hopefully, this knowledge would increase contraceptive knowledge among the pre-teen and teen population.
3. Counselors should seek to promote educational seminars on contraceptive methods within the work setting.

4. There should be an increased awareness of contraceptive knowledge provided through the media since many people would be reached through this avenue. Counselors should seek to design programs which would incorporate the media and community to provide further outreach. This would ensure public knowledge of this issue.
5. Counselors should seek to incorporate additional training to ensure that effective counseling is provided to women regarding the use of contraceptives. These counselors should also engage in training which focuses on values clarification and the importance of not imposing these values on clients in order to ensure effective counseling.

Many of the above-mentioned recommendations are being carried out in some form or another by health care professionals. Also, the field of family planning traditionally demanded women's rights to control their bodies through controlling reproduction. However, there is a need for a continued and increased awareness in the

area of family planning and contraceptive education as the results of this study appear to suggest.

Limitations of the Study

Most research studies have limitations which should be recognized in order to facilitate future research. The present study incorporated survey research to gather information about repeat abortion patients. A limitation that is inherent in any self-report research is that survey respondents are subject to reporting information that they may feel is viewed as acceptable and therefore expected of them. This tends to be especially true of women since they may continue to invest in the false self-picture of social niceness. Consequently, there are times when an inadequate portrayal is given. As such, caution must be taken in reporting findings of this study as being charactersitic of all repeat abortion patients.

Secondly, the typical survey respondent in this study was middle class and employed full-time. Therefore, it is difficult to generalize the results of this study across socioeconomic lines since this sample did not include women of lower socioeconomic status. This was probably due to the study setting. For example,

the abortion clinic which formed the study site was private and located in a somewhat affluent area of the city. These factors tend to limit women who are of lower socioeconomic status from securing services provided by this facility.

In summary, future research involving abortion patients should incorporate larger, more varied samples to increase the generalizability of the results detailed here. Also, more information should be gathered with regards to characteristics of the subject pool such as medical records and information given by significant others.

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APPENDICES

APPENDIX A

Pre-Abortion Counseling Survey

Appendix A

PRE-ABORTION COUNSELING SURVEY

Instruction: The purpose of this survey is to ask your opinions about issues that may be of concern to you. The researcher guarantees that you will remain anonymous and information will be held in the strictest confidence. Regardless as to your decision, you will not be denied services provided by this agency.

SECTION A.

Listed below are some items which describe you. Please place a check by those items that best fit you.

1. Age

_____ 1. 16 - 20 years

_____ 2. 21 - 25 years

_____ 3. 26 - 30 years

_____ 4. 31 - 35 years

_____ 5. 36 - 40 years

_____ 6. 41 years or older

2. Ethnic Group

_____ 1. Black/Afro-American /African American

_____ 2. White/Caucasian

_____ 3. Asian

_____ 4. Hispanic

_____ 5. Other _____ (specify)

3. Highest Educational Level Achieved

_____ 0. Less than high school

_____ 1. High School

_____ 2. some College

_____ 3. AA/AS degree

_____ 4. BA/BS degree

_____ 5. MA/MS degree

_____ 6. PhD/EdD/MD/JD

4. Religious Preference

_____ 1. Baptist

_____ 2. Methodist

_____ 3. Presbyterian

_____ 4. Episcopal

_____ 5. Catholic

_____ 6. Jewish

_____ 7. Other _____ (specify)

5. Degree of Religiosity

_____ 1. Frequently attend church, synagogue,etc.

_____ 2. Sometimes attend church, synagogue, etc.

_____ 3. Seldom attend church, synagogue, etc.

_____ 4. Never attend church, synagogue, etc.

6. Employment Status (place a check by all those that apply to you)

_____ 1. Self-employed (home maker / housewife)

_____ 2. Self-employed (outside the home)

_____ 3. Employed

_____ 4. Unemployed

_____ 5. Part-time

_____ 6. Full-time

7. **Annual Income, 1989** (include self only)

_____ 0. no income
_____ 1. $1 - $4,999
_____ 2. $5,000 - 9,999
_____ 3. $10,000 - $14,999
_____ 4. $15,000 - $19,999
_____ 5. $20,000 - $24,999
_____ 6. $25,000 - $29,999
_____ 7. $30,000 - $34,999
_____ 8. $35,000 - $39,000
_____ 9. $40,000 - and above

8. **Marital Status**

_____ 1. Single, never married
_____ 2. Married
_____ 3. Separated
_____ 4. Divorced/Widowed

9. **Politically, I define myself as:** (check all that apply)

____ 1. conservative
____ 2. moderate
____ 3. liberal
____ 4. socialist
____ 5. feminist
____ 6. democratic
____ 7. republican
____ 8. independent
____ 9. pro-life
____10. pro-choice
____11. Other _____ (specify)

10. **Number of children**

____ 0. none
____ 1. 1 - 2
____ 2. 3 - 4
____ 3. 4 - 5
____ 4. 6 or more

11. **Number of previous abortions**

____ 1. 1
____ 2. 2
____ 3. 3
____ 4. 4
____ 5. 5
____ 6. 6 or more

12. **Live with your sexual partner/spouse**

____ 1. Yes
____ 2. No

13. **On the average, I engage in sexual intercourse**

____ 0. Not at all
____ 1. 1 - 3 times a week
____ 2. 4 - 7 times a week
____ 3. Other _____ (specify)

14. I learned the facts of life from: (check all that apply)

____ 1. mother/parent

____ 2. relative

____ 3. friends

____ 4. sex education class in school

____ 5. sex education through the media

____ 6. sexual partner

____ 7. Other _____ (specify)

Listed below are various contraceptive methods. Place a check in the column next to the method in response to the request in each column.

A. Have experienced medical problems with this contraceptive method.
B. Do not plan to use this contraceptive method.
C. Am currently using this contraceptive method.
D. Plan to use this contraceptive method in the future.

	A	B	C	D
15. Birth control pills	_____	_____	_____	_____
16. Intrauterine device (IUD)	_____	_____	_____	_____
17. Diaphragm	_____	_____	_____	_____
18. Condoms	_____	_____	_____	_____
19. Cervical cap	_____	_____	_____	_____
20. Birth control gel	_____	_____	_____	_____
21. Birth control foam	_____	_____	_____	_____
22. Contraceptive sponge	_____	_____	_____	_____
23. Spermicidal suppository	_____	_____	_____	_____
24. Other _____ (Specify)	_____	_____	_____	_____
25. None	_____	_____	_____	_____

SECTION B.
Place a check by the one response that most appropriately describes your behavior.

26. I smoke cigarettes.

____ Never ____ Sometimes ____ Frequently ____ Always

27. I have written on public property.

____ Never ____ Sometimes ____ Frequently ____ Always

28. I wear seatbelts when I am driving/riding in a car.

____ Never ____ Sometimes ____ Frequently ____ Always

29. I use condoms while having sexual intercourse.

____ Never ____ Sometimes ____ Frequently ____ Always

30. I have shoplifted.

____ Never ____ Sometimes ____ Frequently ____ Always

31. I drive faster than the speed limit.

____ Never ____ Sometimes ____ Frequently ____ Always

32. I use illegal drugs.

____ Never ____ Sometimes ____ Frequently ____ Always

33. I drink alcohol.

____ Never ____ Sometimes ____ Frequently ____ Always

SECTION C.
Place a check by the one response that most appropriately describes your behavior.

34. I plan when I am going to have sex.

____ Never ____ Sometimes ____ Frequently ____ Always

35. I engage in self-masturbation.

____ Never ____ Sometimes ____ Frequently ____ Always

36. I believe homosexuality is an acceptable lifestyle.

____ Strongly Disagree ____ Disagree ____ Agree ____ Strongly Agree

37. Birth control is the responsibility of both partners.

____ Strongly Disagree ____ Disagree ____ Agree ____ Strongly Agree

38. **Birth control is the responsibility of the female.**

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

39. **Birth control is the responsibility of the male.**

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

40. **I practice a variety of sexual positions.**

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

41. **I am fearful when I have sex that I will get pregnant.**

____ Never ____ Sometimes ____ Frequently ____ Always

42. **I think having sex is more important than romance.**

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

43. **I feel guilty about having sex.**

____ Never ____ Sometimes ____ Frequently ____ Always

44. **I am embarrassed to go into a drug store to buy a birth control method (like pills or condoms).**

____ Never ____ Sometimes ____ Frequently ____ Always

45. **I feel it's OK for me to have sex.**

____ Never ____ Sometimes ____ Frequently ____ Always

46. **I couldn't discuss birth control with my sexual partner without feeling terribly uncomfortable.**

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

47. **I feel embarrassed about using birth control methods because it would imply that I'm promiscuous/sexually loose.**

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

48. **I would feel insulted if my sexual partner brought up the subject of using birth control.**

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

49. **The male should be the dominant sexual partner.**

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

50. **I expect to achieve orgasm when I have sex.**

____ Never ____ Sometimes ____ Frequently ____ Always

SECTION D.
Place a check by the one response that most appropriately describes your behavior and feeling.

51. I have a permanent relationship at the present time.

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

52. I feel couples should make love nearly every day.

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

53. I have a close relationship with my partner at the present time.

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

54. I feel communication is essential for the quality of my sexual relationship to be good.

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

55. I feel communication is essential for the quality of my emotional relationship to be good.

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

56. I don't like explaining to my partner why I made a decision.

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

57. Living together before marriage is often a good idea.

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

58. I share in the expense of dating with my partner.

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

59. My partner's feelings are important in the decision-making process concerning my pregnancy.

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

60. I feel my partner is trustworthy.

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

61. I think romance is more important than having sex.

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

SECTION E.
Place a check by the one response that most appropriately describes your behavior and feeling.

62. I have a desire to have a/another child sometime in my life.

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

63. A woman is not complete without children.

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

64. A child/children make a family complete.

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

65. I believe a child should be raised by both parents.

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

66. I would never date/marry someone who already has children.

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

67. I feel a child should be wanted.

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

68. Having a child when I feel it is the wrong time is a mistake.

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

69. Children are the treasure of life.

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

70. I don't think I have the emotional resources to have a child right now.

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

71. I don't think I have the financial resources to have a child right now.

Strongly Disagree	Disagree	Agree	Strongly Agree
____	_____	_____	_____

APPENDIX B

Letter Requesting Permission to Conduct Study

Appendix B

1840 Jerry Way, Apt. 26
Norcross, Georgia 30093
April ___, 1990

XYZ-Care Surgery Center
5675 Peachtree Dunwoody Road, NE
Building C, Suite 602
Atlanta, Georgia 30342

Dear Mrs. Director:

I hope this letter finds you in the best of health. I am writing this letter to advise you of the time, date and purpose of my research. I appreciate your agreeing to let me use XYZ-Care Surgery Center as the setting for my research study.

I plan to start my research study during the month of April, 1990. I will conduct my research on Tuesdays, Wednesdays, Fridays, and Saturdays. The purpose of my research study will be to present a profile of characteristics of women who have the potential to have repeat abortions. This study will investigate four factors which may be important in identifying women who may be potential abortion repeaters. These four factors are: (1) risk-taking behavior, (2) sexuality, (3) quality of relationships, and (4) attitudes toward children.

I hope this research study will provide characteristics of repeat abortion patients which will aid in the counseling and education given to first time abortion patients. Thank you very much for assisting me in this research study.

Sincerely,

Kathy R. Horne

APPENDIX C

Letter of Request Confirmation

Appendix C

1840 Jerry Way, Apt. 26
Norcross, Georgia 30093
April ___, 1990

XYZ-Care Surgery Center
5675 Peachtree Dunwoody Road, NE
Building C, Suite 602
Atlanta, Georgia 30342

Dear Mrs. Director:

I am pleased to write this letter as a follow-up to our telephone conversation and meeting in which you agreed to let me use XYZ-Care Surgery Center as the setting for my research study. I am very excited at the opportunity to conduct my research at your facility.

I have enclosed an administrative agreement which outlines agreements made by you as the director of XYZ-Care Surgery Center and myself as the principal investigator in regards to the research study. I will be in contact with you soon. Thank you very much for your support and assistance with my research study.

Sincerely,

Kathy R. Horne

Enclosure

APPENDIX D

Administrative Agreement

Appendix D

Administrative Agreement

This agreement involves XYZ-Care Surgery Center and Kathy R. Horne, principal investigator from April ___, 1990 to May ___, 1990.

On the part of Mrs. Director of XYZ-Care Surgery Center, she agrees to:

1. Permit Kathy R. Horne, principal investigator, to enter and use the XYZ-Care Surgery Center as a site for her research study.
2. Communicate this approval to XYZ-Care Surgery Center staff counselors in person regarding the said research study and Kathy R. Horne, principal investigator's intent to train counselors regarding their role in the research study.
3. Permit Kathy R. Horne, principal investigator to train XYZ-Care Surgery Center staff counselors as research team members.
4. Permit Kathy R. Horne, principal investigator to use XYZ-Care Surgery Center clients as survey participants.
5. Collect study data from the staff counselors.

_____ _____

Mrs. Director Date
Director, XYZ-Care Surgery Center

On the part of Kathy R. Horne, principal investigator, she agrees to:

1. Meet with the XYZ-Care Surgery Center staff counselors and inform them of the purpose of the research, their role in the research, and familiarize them with the survey.
2. Train XYZ-Care Surgery Center staff counselors to examine the survey and ensure that survey respondents have completed all survey items.
3. Provide PACS to survey respondents.
4. Collect PACS from XYZ-Care Surgery Center staff counselors.
5. Provide XYZ-Care Surgery Center with written report of study outcomes.
6. Reserve full rights to publication.

_____ _____

Kathy R. Horne
Principal Investigator

Date